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: 141313

Period:
From 10/01/2013
To 09/30/2014

Worksheet S
Parts I-III
Date/Time Prepared:
2/10/2015 10:40 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/10/2015 Time: 10:40 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MASON DISTRICT HOSPITAL (141313) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 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	233,633	97,478	110,244	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	225,658	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		356,357		0	10.00
10.01	RURAL HEALTH CLINIC II	0		29,710		0	10.01
200.00	Total	0	459,291	483,545	110,244	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 2/9/2015 4:26 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 615 NORTH PROMENADE STREET	PO Box:			1.00
2.00	City: HAVANA	State: IL	Zip Code: 62644-0530	County: MASON	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	MASON DISTRICT HOSPITAL	141313	99914	1	07/01/2001	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	MASON DISTRICT HOSPITAL	14Z313	99914		07/01/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MASON DISTRICT HHA	147202	99914		01/09/1982	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	HAVANA MEDICAL ASSOCIATES RHC	143457	99914		02/01/2001	O	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	MASON CITY MEDICAL ASSOCIATES	143462	99914		03/03/2003	O	O	O	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2013	09/30/2014	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: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/9/2015 4:26 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)			39.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				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: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/9/2015 4:26 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: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/9/2015 4:26 pm

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

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

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

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

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

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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:	59,972	0	0	118.01

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

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		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)	120,818	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2014	09/30/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 2/9/2015 4:26 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.	Y			5.00

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	01/11/2013	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 2/9/2015 4:26 pm

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563.888.4404	DAN.LINHART@MCGLADREY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 2/9/2015 4:26 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	01/11/2013			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.		MANAGER		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: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 2/9/2015 4:26 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	25	9,125	15,485.90	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)		25	9,125	15,485.90	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	15,485.90	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				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: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/9/2015 4:26 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)	456	91	680			1.00
2.00	HMO and other (see instructions)	38	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	402	0	404			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	41			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	858	91	1,125			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	858	91	1,125	0.00	177.53	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	3,456	465	23,098	0.00	12.35	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	4,801	3,380	13,680	0.00	31.01	26.00
26.01	RURAL HEALTH CLINIC II	245	730	1,659	0.00	3.89	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	224.78	27.00
28.00	Observation Bed Days		0	159			28.00
29.00	Ambulance Trips	593					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: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/9/2015 4:26 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	175	28	263	1.00
2.00	HMO and other (see instructions)			15	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	175	28	263	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 141313 | Component CCN: 147202 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-4 | Date/Time Prepared: 2/9/2015 4:26 pm

Home Health Agency I | PPS

		1.00	
0.00	County	MASON	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	762	36	184	982	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	170.00	8.00	41.00	219.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.86	0.00	0.86	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		1.78	0.00	1.78	5.00
6.00	Direct Nursing Service		9.24	0.00	9.24	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.47	0.00	0.47	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914			20.00
20.01			99915			20.01

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,002	246	55	0	2,303	21.00
22.00	Skilled Nursing Visit Charges	439,689	56,770	9,307	0	505,766	22.00
23.00	Physical Therapy Visits	629	40	3	0	672	23.00
24.00	Physical Therapy Visit Charges	166,340	10,570	795	0	177,705	24.00
25.00	Occupational Therapy Visits	244	18	1	0	263	25.00
26.00	Occupational Therapy Visit Charges	64,450	4,770	265	0	69,485	26.00
27.00	Speech Pathology Visits	7	3	0	0	10	27.00
28.00	Speech Pathology Visit Charges	1,833	795	0	0	2,628	28.00
29.00	Medical Social Service Visits	6	0	0	0	6	29.00
30.00	Medical Social Service Visit Charges	1,590	0	0	0	1,590	30.00
31.00	Home Health Aide Visits	183	18	1	0	202	31.00
32.00	Home Health Aide Visit Charges	24,267	2,394	133	0	26,794	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	3,071	325	60	0	3,456	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	698,169	75,299	10,500	0	783,968	35.00
36.00	Total Number of Episodes (standard/non outlier)	158		16	0	174	36.00
37.00	Total Number of Outlier Episodes		8		0	8	37.00
38.00	Total Non-Routine Medical Supply Charges	5,854	1,261	149	0	7,264	38.00

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

Provider CCN: 141313 Component CCN: 143457 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-8 Date/Time Prepared: 2/9/2015 4:26 pm

		Rural Health Clinic (RHC) I	Cost	
		1.00		
	Clinic Address and Identification			
1.00	Street	615 PROMENADE BOX 530		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	HAVANA	IL	62644-0530 2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00

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

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

			County				
			4.00				
2.00	City, State, Zip Code, County		MASON				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	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2013 To 09/30/2014	Worksheet S-8 Date/Time Prepared: 2/9/2015 4:26 pm
		Rural Health Clinic (RHC) I	Cost

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

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

Provider CCN: 141313 Component CCN: 143462 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-8 Date/Time Prepared: 2/9/2015 4:26 pm

		Rural Health Clinic (RHC) II	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	615 N PROMENADE	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	HAVANA	IL	62644	2.00

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

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

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

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

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	N	0	13.00

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

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

			County			
			4.00			
2.00	City, State, Zip Code, County		MASON			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	17:00	08:00	17:00			11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2013 To 09/30/2014	Worksheet S-8 Date/Time Prepared: 2/9/2015 4:26 pm
		Rural Health Clinic (RHC) II	Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-10 | Date/Time Prepared: 2/9/2015 4:26 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)	0.633051	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,187,605	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?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,252,860	5.00
6.00	Medicaid charges	3,739,300	6.00
7.00	Medicaid cost (line 1 times line 6)	2,367,168	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	15,397	9.00
10.00	Stand-alone SCHIP charges	33,927	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	21,478	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	6,081	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	1,152,664	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	6,081	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	186,027	18,488	204,515	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	117,765	11,704	129,469	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	117,765	11,704	129,469	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,797,906	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	339,510	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,458,396	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	923,239	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,052,708	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,058,789	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/9/2015 4:26 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		-25,289	-25,289	275,682	250,393	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING		0	0	91,574	91,574	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG		0	0	564,582	564,582	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,261,811	1,261,811	-561,722	700,089	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,451,962	2,451,962	0	2,451,962	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	990,873	1,496,158	2,487,031	0	2,487,031	5.01
5.02	00591	A&G HOSPITAL ONLY	286,658	194,858	481,516	0	481,516	5.02
6.00	00600	MAINTENANCE & REPAIRS	301,530	193,909	495,439	0	495,439	6.00
7.00	00700	OPERATION OF PLANT	0	228,940	228,940	0	228,940	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	19,262	19,262	0	19,262	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	22,736	17,726	40,462	0	40,462	8.00
9.00	00900	HOUSEKEEPING	226,258	68,002	294,260	0	294,260	9.00
10.00	01000	DIETARY	212,370	191,829	404,199	0	404,199	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	205,961	24,512	230,473	0	230,473	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	46,853	26,383	73,236	0	73,236	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	138,353	64,415	202,768	0	202,768	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	306,975	306,975	0	306,975	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	956,966	207,861	1,164,827	0	1,164,827	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	214,438	61,641	276,079	0	276,079	50.00
53.00	05300	ANESTHESIOLOGY	0	469	469	0	469	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	464,079	262,256	726,335	-100,945	625,390	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	61,940	58,603	120,543	3,659	124,202	54.01
56.00	05600	RADIOISOTOPE	49,611	85,678	135,289	878	136,167	56.00
58.00	05800	MRI	0	109,499	109,499	1,671	111,170	58.00
60.00	06000	LABORATORY	606,114	543,780	1,149,894	72,487	1,222,381	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	41,929	41,929	0	41,929	62.00
64.00	06400	INTRAVENOUS THERAPY	0	7,059	7,059	0	7,059	64.00
66.00	06600	PHYSICAL THERAPY	428,122	126,950	555,072	0	555,072	66.00
67.00	06700	OCCUPATIONAL THERAPY	108,143	46,601	154,744	0	154,744	67.00
68.00	06800	SPEECH PATHOLOGY	8,872	1,208	10,080	0	10,080	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	384,440	117,960	502,400	22,250	524,650	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	300,583	300,583	0	300,583	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	235,527	427,239	662,766	0	662,766	73.00
76.00	03020	OP SENIOR HEALTH	216,851	135,816	352,667	0	352,667	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	5,507	13,022	18,529	0	18,529	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,430,092	529,582	2,959,674	-89,341	2,870,333	88.00
88.01	08801	RURAL HEALTH CLINIC II	257,872	76,199	334,071	0	334,071	88.01
91.00	09100	EMERGENCY	319,919	1,344,364	1,664,283	559,397	2,223,680	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	818,397	84,477	902,874	-559,397	343,477	95.00
101.00	10100	HOME HEALTH AGENCY	505,391	101,639	607,030	0	607,030	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		370,116	370,116	-370,116	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,503,873	11,575,984	22,079,857	-89,341	21,990,516	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,786	1,026	24,812	89,341	114,153	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	10,527,659	11,577,010	22,104,669	0	22,104,669	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/9/2015 4:26 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	6,549	256,942		1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	91,574		1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	-47,166	517,416		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-169,847	530,242		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-738,086	1,713,876		4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	-23,977	2,463,054		5.01
5.02	00591	A&G HOSPITAL ONLY	-2,746	478,770		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	495,439		6.00
7.00	00700	OPERATION OF PLANT	-276	228,664		7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	19,262		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	40,462		8.00
9.00	00900	HOUSEKEEPING	0	294,260		9.00
10.00	01000	DIETARY	-148,027	256,172		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	230,473		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	73,236		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,903	197,865		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	306,975		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,164,827		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	276,079		50.00
53.00	05300	ANESTHESIOLOGY	0	469		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-32,768	592,622		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	124,202		54.01
56.00	05600	RADIOISOTOPE	0	136,167		56.00
58.00	05800	MRI	0	111,170		58.00
60.00	06000	LABORATORY	-48	1,222,333		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	41,929		62.00
64.00	06400	INTRAVENOUS THERAPY	0	7,059		64.00
66.00	06600	PHYSICAL THERAPY	0	555,072		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	154,744		67.00
68.00	06800	SPEECH PATHOLOGY	0	10,080		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	-52,787	471,863		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	300,583		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	662,766		73.00
76.00	03020	OP SENIOR HEALTH	0	352,667		76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	18,529		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-75	2,870,258		88.00
88.01	08801	RURAL HEALTH CLINIC II	-75	333,996		88.01
91.00	09100	EMERGENCY	-369,973	1,853,707		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	343,477		95.00
101.00	10100	HOME HEALTH AGENCY	0	607,030		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,584,205	20,406,311		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	114,153		192.00
194.00	07950	HOSPICE	0	0		194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0		194.01
194.02	07952	MEALS ON WHEELS	0	0		194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-1,584,205	20,520,464		200.00

RECLASSIFICATIONS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/9/2015 4:26 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	92,970		1.00
2.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	277,146		2.00
	TOTALS		0	370,116		
	B - EMS SALARY TO ER					
1.00	EMERGENCY	91.00	559,397	0		1.00
	TOTALS		559,397	0		
	C - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	182,712		1.00
2.00	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	91,574		2.00
3.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	287,436		3.00
	TOTALS		0	561,722		
	D - RHC PHYSICIAN					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	89,341	0		1.00
	TOTALS		89,341	0		
	E - OP REGISTRATION					
1.00	LABORATORY	60.00	64,998	7,489		1.00
2.00	CARDIOPULMONARY	69.01	19,951	2,299		2.00
3.00	RADIOLOGY-ULTRASOUND	54.01	3,281	378		3.00
4.00	RADIOISOTOPE	56.00	787	91		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	5,571	642		5.00
6.00	MRI	58.00	1,498	173		6.00
	TOTALS		96,086	11,072		
500.00	Grand Total: Increases		744,824	942,910		500.00

RECLASSIFICATIONS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/9/2015 4:26 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	370,116	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	370,116			
	B - EMS SALARY TO ER						
1.00	AMBULANCE SERVICES	95.00	559,397	0	0		1.00
	TOTALS		559,397	0			
	C - DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	561,722	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	561,722			
	D - RHC PHYSICIAN						
1.00	RURAL HEALTH CLINIC	88.00	89,341	0	0		1.00
	TOTALS		89,341	0			
	E - OP REGISTRATION						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	96,086	11,072	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		96,086	11,072			
500.00	Grand Total: Decreases		744,824	942,910			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 2/9/2015 4:26 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	163,928	0	0	0	0	1.00
2.00	Land Improvements	582,643	0	0	0	0	2.00
3.00	Buildings and Fixtures	14,389,110	87,112	0	87,112	-7,049	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,264,281	120,821	0	120,821	0	5.00
6.00	Movable Equipment	7,595,240	324,135	0	324,135	7,049	6.00
7.00	HIT designated Assets	689,559	120,818	0	120,818	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,684,761	652,886	0	652,886	0	8.00
9.00	Reconciling Items	-58,627	-313,365	0	-313,365	0	9.00
10.00	Total (line 8 minus line 9)	26,743,388	966,251	0	966,251	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	163,928	0	1.00
2.00	Land Improvements	582,643	0	2.00
3.00	Buildings and Fixtures	14,483,271	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	3,385,102	0	5.00
6.00	Movable Equipment	7,912,326	0	6.00
7.00	HIT designated Assets	810,377	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,337,647	0	8.00
9.00	Reconciling Items	-371,992	0	9.00
10.00	Total (line 8 minus line 9)	27,709,639	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 2/9/2015 4:26 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	-25,289	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	1,261,811	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,236,522	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	-25,289		1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0		1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0		1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,261,811		2.00
3.00	Total (sum of lines 1-2)	0	1,236,522		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part III | Date/Time Prepared: 2/9/2015 4:26 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	18,986,936	0	18,986,936	0.685211	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	8,722,703	0	8,722,703	0.314789	0	2.00
3.00	Total (sum of lines 1-2)	27,709,639	0	27,709,639	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	153,573	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	91,574	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	286,234	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	530,242	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,061,623	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	77,551	0	0	25,818	256,942	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	91,574	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	231,182	0	0	0	517,416	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	530,242	2.00
3.00	Total (sum of lines 1-2)	308,733	0	0	25,818	1,396,174	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/9/2015 4:26 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-CLINIC BUILDING (chapter 2)		0	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-NEW MED SURG (chapter 2)		0	NEW CAP REL COSTS-NEW MED SURG	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-431,377			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-CLINIC BUILDING		0	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-NEW MED SURG		0	NEW CAP REL COSTS-NEW MED SURG	1.02	0	26.02
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

ADJUSTMENTS TO EXPENSES | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/9/2015 4:26 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	
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	-169,847	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MEDICAL RECORD FEES -OTHER OP	B	-4,786	MEDICAL RECORDS & LIBRARY	16.00	0	33.00
33.01	CAFETERIA SALES -OTHER OP	B	-147,227	DIETARY	10.00	0	33.01
33.02	SALE OF NON-PAT SUPP-OTHER OP	B	1,408	ADMINISTRATIVE AND GENERAL	5.01	0	33.02
33.03	MISCELLANEOUS -OTHER OP	B	-4,283	ADMINISTRATIVE AND GENERAL	5.01	0	33.03
33.04	RENTAL INCOME	B	-3,850	CAP REL COSTS-BLDG & FIXT	1.00	9	33.04
33.05	COMMUNITY ED FEES -OTHER OP	B	-550	ADMINISTRATIVE AND GENERAL	5.01	0	33.05
33.06	LAB OUTREACH REV -OTHER OP	B	-48	LABORATORY	60.00	0	33.06
33.07	MED REC FEES - MISC REV	B	-117	MEDICAL RECORDS & LIBRARY	16.00	0	33.07
33.08	INTEREST INCOME -NON OPER	B	-15,419	CAP REL COSTS-BLDG & FIXT	1.00	11	33.08
33.09	INTEREST INCOME -NON OPER	B	-45,964	NEW CAP REL COSTS-NEW MED SURG	1.02	11	33.09
33.10	FITNESS REV OTHER	B	-10,631	CARDIOPULMONARY	69.01	0	33.10
33.11	BOND AMORTIZTION COST FY14	A	25,818	CAP REL COSTS-BLDG & FIXT	1.00	14	33.11
33.12	TELEPHONE OFFSET - OPERATIONS	A	-276	OPERATION OF PLANT	7.00	0	33.12
33.13	TELEPHONE OFFSET - SALARIES	A	-74	ADMINISTRATIVE AND GENERAL	5.01	0	33.13
33.14	TELEPHONE OFFSET - BENEFITS	A	-13	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.14
33.15	MEDICAR - EXPENSES	A	-17,695	ADMINISTRATIVE AND GENERAL	5.01	0	33.15
33.16	MEDICAR - BENEFITS	A	-2,045	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.16
33.17	LOBBYING DUES	A	-2,148	ADMINISTRATIVE AND GENERAL	5.01	0	33.17
33.18	ADVERTISING	A	-26,453	ADMINISTRATIVE AND GENERAL	5.01	0	33.18
33.19	ADVERTISING	A	-2,746	A&G HOSPITAL ONLY	5.02	0	33.19
33.20	ADVERTISING	A	-75	RURAL HEALTH CLINIC	88.00	0	33.20
36.00	ADVERTISING	A	-75	RURAL HEALTH CLINIC II	88.01	0	36.00
36.01	FITNESS CENT REVENUE	B	-13,520	CARDIOPULMONARY	69.01	0	36.01
36.02	DIETARY CONSULT - OTHER OP	B	-800	DIETARY	10.00	0	36.02
38.00	TELEVISIONS	A	-1,202	NEW CAP REL COSTS-NEW MED SURG	1.02	9	38.00
39.00	SELF INSURANCE	A	-682,028	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	39.00
40.00	UNFUNDED POST-EMPLOYMENT BENEFIT	A	-54,000	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.01	BOND AMORTIZTION COST FY14	A	25,818	ADMINISTRATIVE AND GENERAL	5.01	0	41.01
42.00			0		0.00	0	42.00
42.01			0		0.00	0	42.01
43.00			0		0.00	0	43.00
43.01			0		0.00	0	43.01
43.02			0		0.00	0	43.02
43.03			0		0.00	0	43.03
43.04			0		0.00	0	43.04
43.05			0		0.00	0	43.05
43.07			0		0.00	0	43.07
45.00			0		0.00	0	45.00
45.01			0		0.00	0	45.01
45.02			0		0.00	0	45.02
45.03			0		0.00	0	45.03
45.05			0		0.00	0	45.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,584,205				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: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 2/9/2015 4:26 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,257,984	369,973	888,011	0	0	1.00
2.00	60.00	LABORATORY	48,000	0	48,000	0	0	2.00
3.00	69.01	CARDIOPULMONARY	28,636	28,636	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	32,768	32,768	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,367,388	431,377	936,011		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	369,973		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	28,636		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	32,768		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	431,377		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I Date/Time Prepared: 2/9/2015 4:26 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	256,942	256,942				1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	91,574	0	91,574			1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	517,416	0	0	517,416		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	530,242				530,242	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,713,876	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	2,463,054	51,687	4,858	71,550	7,786	5.01
5.02	00591	A&G HOSPITAL ONLY	478,770	2,538	5,983	4,247	6,274	5.02
6.00	00600	MAINTENANCE & REPAIRS	495,439	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	228,664	26,410	767	11,326	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	19,262	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	40,462	7,778	0	4,209	3,068	8.00
9.00	00900	HOUSEKEEPING	294,260	932	0	2,487	0	9.00
10.00	01000	DIETARY	256,172	12,644	0	0	985	10.00
11.00	01100	CAFETERIA	0	5,375	0	2,870	0	11.00
13.00	01300	NURSING ADMINISTRATION	230,473	5,240	0	6,160	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	73,236	6,761	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	197,865	6,382	931	0	68,678	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	306,975	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,164,827	3,849	0	403,356	17,309	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	276,079	31,121	0	0	40,171	50.00
53.00	05300	ANESTHESIOLOGY	469	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	592,622	23,428	0	0	210,713	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	124,202	1,212	0	0	0	54.01
56.00	05600	RADIOISOTOPE	136,167	2,632	0	0	0	56.00
58.00	05800	MRI	111,170	0	0	0	0	58.00
60.00	06000	LABORATORY	1,222,333	13,496	0	0	4,792	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	41,929	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	7,059	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	555,072	5,135	0	0	80,285	66.00
67.00	06700	OCCUPATIONAL THERAPY	154,744	1,077	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,080	778	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	471,863	24,261	0	0	15,330	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	300,583	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	662,766	3,829	0	0	500	73.00
76.00	03020	OP SENIOR HEALTH	352,667	0	3,897	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	18,529	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,870,258	0	67,204	0	9,184	88.00
88.01	08801	RURAL HEALTH CLINIC II	333,996	0	0	0	977	88.01
91.00	09100	EMERGENCY	1,853,707	20,377	0	0	1,572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	343,477	0	0	0	55,615	95.00
101.00	10100	HOME HEALTH AGENCY	607,030	0	7,934	0	6,454	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,406,311	256,942	91,574	506,205	529,693	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,211	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	114,153	0	0	0	549	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	20,520,464	256,942	91,574	517,416	530,242	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/9/2015 4:26 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	A&G HOSPITAL ONLY	
			4.00	4A	5.01	5A.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,713,876					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	159,590	2,758,525	2,758,525			5.01
5.02	00591	A&G HOSPITAL ONLY	46,719	544,531	84,568	629,099	629,099	5.02
6.00	00600	MAINTENANCE & REPAIRS	49,143	544,582	84,576	629,158	27,029	6.00
7.00	00700	OPERATION OF PLANT	0	267,167	41,492	308,659	13,260	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	19,262	2,991	22,253	956	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	3,705	59,222	9,197	68,419	2,939	8.00
9.00	00900	HOUSEKEEPING	36,875	334,554	51,958	386,512	16,605	9.00
10.00	01000	DIETARY	34,612	304,413	47,277	351,690	15,109	10.00
11.00	01100	CAFETERIA	0	8,245	1,280	9,525	409	11.00
13.00	01300	NURSING ADMINISTRATION	33,567	275,440	42,777	318,217	13,671	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,636	87,633	13,610	101,243	4,349	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,548	296,404	46,033	342,437	14,711	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	306,975	47,675	354,650	15,236	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	155,964	1,745,305	271,055	2,016,360	86,623	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,949	382,320	59,376	441,696	18,975	50.00
53.00	05300	ANESTHESIOLOGY	0	469	73	542	23	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	60,883	887,646	137,856	1,025,502	44,056	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	10,630	136,044	21,128	157,172	6,752	54.01
56.00	05600	RADIOISOTOPE	8,214	147,013	22,832	169,845	7,297	56.00
58.00	05800	MRI	244	111,414	17,303	128,717	5,530	58.00
60.00	06000	LABORATORY	109,376	1,349,997	209,661	1,559,658	67,003	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	41,929	6,512	48,441	2,081	62.00
64.00	06400	INTRAVENOUS THERAPY	0	7,059	1,096	8,155	350	64.00
66.00	06600	PHYSICAL THERAPY	69,774	710,266	110,308	820,574	35,252	66.00
67.00	06700	OCCUPATIONAL THERAPY	17,625	173,446	26,937	200,383	8,608	67.00
68.00	06800	SPEECH PATHOLOGY	1,446	12,304	1,911	14,215	611	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	65,907	577,361	89,667	667,028	28,656	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	300,583	46,682	347,265	14,919	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	38,386	705,481	109,565	815,046	35,014	73.00
76.00	03020	OP SENIOR HEALTH	35,342	391,906	60,865	452,771	19,451	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	898	19,427	3,017	22,444	964	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	380,747	3,327,393	516,770	3,844,163	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	42,027	377,000	58,550	435,550	0	88.01
91.00	09100	EMERGENCY	143,309	2,018,965	313,555	2,332,520	100,201	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	42,211	441,303	68,537	509,840	21,903	95.00
101.00	10100	HOME HEALTH AGENCY	82,368	703,786	109,301	813,087	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,694,695	20,375,370	2,735,991	20,352,836	628,543	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,211	1,741	12,952	556	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	19,181	133,883	20,793	154,676	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,713,876	20,520,464	2,758,525	20,520,464	629,099	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I Date/Time Prepared: 2/9/2015 4:26 pm

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			6.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS	656,187					6.00
7.00	00700	OPERATION OF PLANT	55,117	377,036				7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	23,209			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	16,007	13,308	0	100,673		8.00
9.00	00900	HOUSEKEEPING	2,426	2,017	0	0	407,560	9.00
10.00	01000	DIETARY	24,322	20,222	0	0	17,013	10.00
11.00	01100	CAFETERIA	11,058	9,194	0	0	7,735	11.00
13.00	01300	NURSING ADMINISTRATION	11,614	9,656	0	0	8,124	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,005	10,813	0	0	9,097	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,069	11,698	300	0	9,842	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	108,508	90,216	0	39,855	75,902	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,864	49,773	0	16,128	41,876	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,066	37,469	0	1,244	35,066	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	2,331	1,938	0	0	1,630	54.01
56.00	05600	RADIOISOTOPE	5,064	4,210	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	25,962	21,585	0	3,204	18,160	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	9,878	8,213	0	760	6,910	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,072	1,722	0	0	1,449	67.00
68.00	06800	SPEECH PATHOLOGY	1,496	1,244	0	0	1,047	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	46,668	38,801	0	315	32,645	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,366	6,124	0	0	5,152	73.00
76.00	03020	OP SENIOR HEALTH	7,509	6,244	1,256	0	5,253	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	129,491	0	21,653	165	90,581	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	960	0	88.01
91.00	09100	EMERGENCY	39,197	32,589	0	22,399	27,418	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	15,539	0	95.00
101.00	10100	HOME HEALTH AGENCY	15,287	0	0	18	10,694	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	653,377	377,036	23,209	100,587	405,594	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,810	0	0	0	1,966	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	86	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	656,187	377,036	23,209	100,673	407,560	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/9/2015 4:26 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	428,356					10.00
11.00	01100	CAFETERIA	330,524	368,445				11.00
13.00	01300	NURSING ADMINISTRATION	0	5,355	366,637			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,880	0	142,387		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,727	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	72,800	56,962	214,525	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,379	10,761	42,069	182	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,265	0	3,332	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	2,949	0	77	0	54.01
56.00	05600	RADIOISOTOPE	0	1,604	0	12,487	0	56.00
58.00	05800	MRI	0	155	0	615	0	58.00
60.00	06000	LABORATORY	0	31,353	0	57,291	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	8,228	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	1,385	0	64.00
66.00	06600	PHYSICAL THERAPY	0	17,384	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,777	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	181	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	27,524	0	4,684	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	53,014	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,235	0	0	0	73.00
76.00	03020	OP SENIOR HEALTH	23,333	11,563	45,259	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	336	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	79,572	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	320	69,741	64,784	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	1,092	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	428,356	366,324	366,637	142,387	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,121	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	428,356	368,445	366,637	142,387	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/9/2015 4:26 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
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	402,784					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	369,886				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,333	0	2,786,084	0	2,786,084	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,016	0	696,719	0	696,719	50.00
53.00	05300	ANESTHESIOLOGY	9,370	369,886	379,821	0	379,821	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	64,983	0	1,280,983	0	1,280,983	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	7,395	0	180,244	0	180,244	54.01
56.00	05600	RADIOISOTOPE	7,479	0	207,986	0	207,986	56.00
58.00	05800	MRI	12,311	0	147,328	0	147,328	58.00
60.00	06000	LABORATORY	79,747	0	1,863,963	0	1,863,963	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	786	0	59,536	0	59,536	62.00
64.00	06400	INTRAVENOUS THERAPY	5,947	0	15,837	0	15,837	64.00
66.00	06600	PHYSICAL THERAPY	17,831	0	916,802	0	916,802	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,639	0	222,650	0	222,650	67.00
68.00	06800	SPEECH PATHOLOGY	172	0	18,966	0	18,966	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	17,100	0	863,421	0	863,421	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,316	0	424,514	0	424,514	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,511	0	888,448	0	888,448	73.00
76.00	03020	OP SENIOR HEALTH	11,318	0	583,957	0	583,957	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	539	0	24,283	0	24,283	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	38,494	0	4,204,119	0	4,204,119	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,344	0	439,854	0	439,854	88.01
91.00	09100	EMERGENCY	28,550	0	2,717,719	0	2,717,719	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	21,162	0	569,536	0	569,536	95.00
101.00	10100	HOME HEALTH AGENCY	13,441	0	852,527	0	852,527	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	402,784	369,886	20,345,297	0	20,345,297	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	18,284	0	18,284	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	156,883	0	156,883	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
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)	402,784	369,886	20,520,464	0	20,520,464	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II Date/Time Prepared: 2/9/2015 4:26 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	0	51,687	4,858	71,550	7,786	5.01
5.02	00591	A&G HOSPITAL ONLY	0	2,538	5,983	4,247	6,274	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	26,410	767	11,326	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,778	0	4,209	3,068	8.00
9.00	00900	HOUSEKEEPING	0	932	0	2,487	0	9.00
10.00	01000	DIETARY	0	12,644	0	0	985	10.00
11.00	01100	CAFETERIA	0	5,375	0	2,870	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,240	0	6,160	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,761	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,382	931	0	68,678	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,849	0	403,356	17,309	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	31,121	0	0	40,171	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,428	0	0	210,713	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	1,212	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	2,632	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	13,496	0	0	4,792	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	5,135	0	0	80,285	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,077	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	778	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	24,261	0	0	15,330	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,829	0	0	500	73.00
76.00	03020	OP SENIOR HEALTH	0	0	3,897	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	67,204	0	9,184	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	977	88.01
91.00	09100	EMERGENCY	0	20,377	0	0	1,572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	55,615	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	7,934	0	6,454	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	256,942	91,574	506,205	529,693	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,211	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	549	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	256,942	91,574	517,416	530,242	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/9/2015 4:26 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE AND GENERAL	A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	
			2A	4.00	5.01	5.02	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	135,881	0	135,881			5.01
5.02	00591	A&G HOSPITAL ONLY	19,042	0	4,166	23,208		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	4,166	997	5,163	6.00
7.00	00700	OPERATION OF PLANT	38,503	0	2,044	489	434	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	147	35	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	15,055	0	453	108	126	8.00
9.00	00900	HOUSEKEEPING	3,419	0	2,559	613	19	9.00
10.00	01000	DIETARY	13,629	0	2,329	557	191	10.00
11.00	01100	CAFETERIA	8,245	0	63	15	87	11.00
13.00	01300	NURSING ADMINISTRATION	11,400	0	2,107	504	91	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,761	0	670	160	102	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	75,991	0	2,267	543	111	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	2,348	562	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	424,514	0	13,352	3,196	854	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	71,292	0	2,925	700	471	50.00
53.00	05300	ANESTHESIOLOGY	0	0	4	1	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	234,141	0	6,790	1,625	355	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	1,212	0	1,041	249	18	54.01
56.00	05600	RADIOISOTOPE	2,632	0	1,125	269	40	56.00
58.00	05800	MRI	0	0	852	204	0	58.00
60.00	06000	LABORATORY	18,288	0	10,327	2,472	204	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	321	77	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	54	13	0	64.00
66.00	06600	PHYSICAL THERAPY	85,420	0	5,434	1,301	78	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,077	0	1,327	318	16	67.00
68.00	06800	SPEECH PATHOLOGY	778	0	94	23	12	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	39,591	0	4,417	1,057	367	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,299	550	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,329	0	5,397	1,292	58	73.00
76.00	03020	OP SENIOR HEALTH	3,897	0	2,998	718	59	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	149	36	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	76,388	0	25,457	0	1,020	88.00
88.01	08801	RURAL HEALTH CLINIC II	977	0	2,884	0	0	88.01
91.00	09100	EMERGENCY	21,949	0	15,445	3,695	308	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	55,615	0	3,376	808	0	95.00
101.00	10100	HOME HEALTH AGENCY	14,388	0	5,384	0	120	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,384,414	0	134,771	23,187	5,141	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,211	0	86	21	22	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	549	0	1,024	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,396,174	0	135,881	23,208	5,163	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II Date/Time Prepared: 2/9/2015 4:26 pm

		Cost Center Description	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	41,470					7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	182				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,464	0	17,206			8.00
9.00	00900	HOUSEKEEPING	222	0	0	6,832		9.00
10.00	01000	DIETARY	2,224	0	0	285	19,215	10.00
11.00	01100	CAFETERIA	1,011	0	0	130	14,826	11.00
13.00	01300	NURSING ADMINISTRATION	1,062	0	0	136	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,189	0	0	152	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,287	2	0	165	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,924	0	6,811	1,272	3,266	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,474	0	2,756	702	62	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,121	0	213	588	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	213	0	0	27	0	54.01
56.00	05600	RADIOISOTOPE	463	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,374	0	548	304	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	903	0	130	116	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	189	0	0	24	0	67.00
68.00	06800	SPEECH PATHOLOGY	137	0	0	18	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,268	0	54	547	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	674	0	0	86	0	73.00
76.00	03020	OP SENIOR HEALTH	687	10	0	88	1,047	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	170	28	1,520	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	164	0	0	88.01
91.00	09100	EMERGENCY	3,584	0	3,828	460	14	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	2,656	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	3	179	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,470	182	17,191	6,799	19,215	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	33	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	15	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	41,470	182	17,206	6,832	19,215	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/9/2015 4:26 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
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	24,377					11.00
13.00	01300	NURSING ADMINISTRATION	354	15,654				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	257	0	9,291			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	644	0	0	0	81,010	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,769	9,160	0	0	4,895	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	712	1,796	12	0	2,819	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,885	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,605	0	217	0	13,071	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	195	0	5	0	1,487	54.01
56.00	05600	RADIOISOTOPE	106	0	815	0	1,504	56.00
58.00	05800	MRI	10	0	40	0	2,476	58.00
60.00	06000	LABORATORY	2,074	0	3,739	0	16,031	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	537	0	158	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	90	0	1,196	64.00
66.00	06600	PHYSICAL THERAPY	1,150	0	0	0	3,587	66.00
67.00	06700	OCCUPATIONAL THERAPY	250	0	0	0	933	67.00
68.00	06800	SPEECH PATHOLOGY	12	0	0	0	35	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	1,821	0	306	0	3,440	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,459	0	1,874	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	611	0	0	0	2,114	73.00
76.00	03020	OP SENIOR HEALTH	765	1,932	0	0	2,277	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	22	0	0	0	108	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,266	0	0	0	7,743	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	673	88.01
91.00	09100	EMERGENCY	4,614	2,766	0	0	5,743	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	71	0	4,257	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	2,704	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,237	15,654	9,291	0	81,010	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	140	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,377	15,654	9,291	0	81,010	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/9/2015 4:26 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
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
19.00	01900	NONPHYSICIAN ANESTHETISTS	2,910					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		481,013	0	481,013		30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		89,721	0	89,721		50.00
53.00	05300	ANESTHESIOLOGY		1,890	0	1,890		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		262,726	0	262,726		54.00
54.01	05401	RADIOLOGY-ULTRASOUND		4,447	0	4,447		54.01
56.00	05600	RADIOISOTOPE		6,954	0	6,954		56.00
58.00	05800	MRI		3,582	0	3,582		58.00
60.00	06000	LABORATORY		56,361	0	56,361		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		1,093	0	1,093		62.00
64.00	06400	INTRAVENOUS THERAPY		1,353	0	1,353		64.00
66.00	06600	PHYSICAL THERAPY		98,119	0	98,119		66.00
67.00	06700	OCCUPATIONAL THERAPY		4,134	0	4,134		67.00
68.00	06800	SPEECH PATHOLOGY		1,109	0	1,109		68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0		69.00
69.01	03160	CARDIOPULMONARY		55,868	0	55,868		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		8,182	0	8,182		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		14,561	0	14,561		73.00
76.00	03020	OP SENIOR HEALTH		14,478	0	14,478		76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES		315	0	315		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		117,592	0	117,592		88.00
88.01	08801	RURAL HEALTH CLINIC II		4,698	0	4,698		88.01
91.00	09100	EMERGENCY		62,406	0	62,406		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE		0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		66,783	0	66,783		95.00
101.00	10100	HOME HEALTH AGENCY		22,778	0	22,778		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,380,163	0	1,380,163		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		11,373	0	11,373		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		1,728	0	1,728		192.00
194.00	07950	HOSPICE		0	0	0		194.00
194.01	07951	FAMILY MEDICAL CENTER		0	0	0		194.01
194.02	07952	MEALS ON WHEELS		0	0	0		194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS		0	0	0		194.04
200.00		Cross Foot Adjustments	2,910	2,910	0	2,910		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	2,910	1,396,174	0	1,396,174		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/9/2015 4:26 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	51,535					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	18,398				1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	0	0	13,523			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				530,442		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	10,516,000	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	10,367	976	1,870	7,789	979,213	5.01
5.02	00591	A&G HOSPITAL ONLY	509	1,202	111	6,276	286,658	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	301,530	6.00
7.00	00700	OPERATION OF PLANT	5,297	154	296	0	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,560	0	110	3,069	22,736	8.00
9.00	00900	HOUSEKEEPING	187	0	65	0	226,258	9.00
10.00	01000	DIETARY	2,536	0	0	985	212,370	10.00
11.00	01100	CAFETERIA	1,078	0	75	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,051	0	161	0	205,961	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,356	0	0	0	46,853	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,280	187	0	68,704	138,353	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	772	0	10,542	17,316	956,966	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,242	0	0	40,186	214,438	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,699	0	0	210,794	373,565	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	0	65,221	54.01
56.00	05600	RADIOISOTOPE	528	0	0	0	50,398	56.00
58.00	05800	MRI	0	0	0	0	1,498	58.00
60.00	06000	LABORATORY	2,707	0	0	4,794	671,112	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	0	80,315	428,122	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	0	108,143	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	0	8,872	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,866	0	0	15,336	404,391	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	768	0	0	500	235,527	73.00
76.00	03020	OP SENIOR HEALTH	0	783	0	0	216,851	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	5,507	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,502	0	9,187	2,336,187	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	977	257,872	88.01
91.00	09100	EMERGENCY	4,087	0	0	1,573	879,316	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	55,636	259,000	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,594	0	6,456	505,391	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,535	18,398	13,230	529,893	10,398,309	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	293	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	549	117,691	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	256,942	91,574	517,416	530,242	1,713,876	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.985777	4.977389	38.261924	0.999623	0.162978	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/9/2015 4:26 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	
		1.00	1.01	1.02	2.00	4.00	
205.00	Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/9/2015 4:26 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5A.01	5.01	5A.02	5.02	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	-2,758,525	17,761,939				5.01
5.02	00591	A&G HOSPITAL ONLY	0	544,531	-629,099	14,643,889		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	544,582	0	629,158	68,420	6.00
7.00	00700	OPERATION OF PLANT	0	267,167	0	308,659	5,747	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	19,262	0	22,253	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	59,222	0	68,419	1,669	8.00
9.00	00900	HOUSEKEEPING	0	334,554	0	386,512	253	9.00
10.00	01000	DIETARY	0	304,413	0	351,690	2,536	10.00
11.00	01100	CAFETERIA	0	8,245	0	9,525	1,153	11.00
13.00	01300	NURSING ADMINISTRATION	0	275,440	0	318,217	1,211	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	87,633	0	101,243	1,356	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	296,404	0	342,437	1,467	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	306,975	0	354,650	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,745,305	0	2,016,360	11,314	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	382,320	0	441,696	6,242	50.00
53.00	05300	ANESTHESIOLOGY	0	469	0	542	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	887,646	0	1,025,502	4,699	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	136,044	0	157,172	243	54.01
56.00	05600	RADIOISOTOPE	0	147,013	0	169,845	528	56.00
58.00	05800	MRI	0	111,414	0	128,717	0	58.00
60.00	06000	LABORATORY	0	1,349,997	0	1,559,658	2,707	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	41,929	0	48,441	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	7,059	0	8,155	0	64.00
66.00	06600	PHYSICAL THERAPY	0	710,266	0	820,574	1,030	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	173,446	0	200,383	216	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,304	0	14,215	156	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	577,361	0	667,028	4,866	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	300,583	0	347,265	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	705,481	0	815,046	768	73.00
76.00	03020	OP SENIOR HEALTH	0	391,906	0	452,771	783	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	19,427	0	22,444	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,327,393	-3,844,163	0	13,502	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	377,000	-435,550	0	0	88.01
91.00	09100	EMERGENCY	0	2,018,965	0	2,332,520	4,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	441,303	0	509,840	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	703,786	-813,087	0	1,594	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,758,525	17,616,845	-5,721,899	14,630,937	68,127	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,211	0	12,952	293	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	133,883	-154,676	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		2,758,525		629,099	656,187	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.155305		0.042960	9.590573	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		135,881		23,208	5,163	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.007650		0.001585	0.075460	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/9/2015 4:26 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	47,284					7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	14,472				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,669	0	57,471			8.00
9.00	00900	HOUSEKEEPING	253	0	0	60,751		9.00
10.00	01000	DIETARY	2,536	0	0	2,536	30,750	10.00
11.00	01100	CAFETERIA	1,153	0	0	1,153	23,727	11.00
13.00	01300	NURSING ADMINISTRATION	1,211	0	0	1,211	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,356	0	0	1,356	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,467	187	0	1,467	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,314	0	22,752	11,314	5,226	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,242	0	9,207	6,242	99	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,699	0	710	5,227	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	243	0	54.01
56.00	05600	RADIOISOTOPE	528	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,707	0	1,829	2,707	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	434	1,030	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	216	0	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	156	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,866	0	180	4,866	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	768	0	0	768	0	73.00
76.00	03020	OP SENIOR HEALTH	783	783	0	783	1,675	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,502	94	13,502	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	548	0	0	88.01
91.00	09100	EMERGENCY	4,087	0	12,787	4,087	23	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	8,871	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	10	1,594	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,284	14,472	57,422	60,458	30,750	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	293	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	49	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	377,036	23,209	100,673	407,560	428,356	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.973860	1.603718	1.751718	6.708696	13.930276	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,470	182	17,206	6,832	19,215	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.877041	0.012576	0.299386	0.112459	0.624878	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/9/2015 4:26 pm

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	14,243					11.00
13.00	01300	NURSING ADMINISTRATION	207	75,394				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	150	0	725,584			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	376	0	0	0	32,138,501	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,202	44,114	0	0	1,941,493	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	416	8,651	925	0	1,118,340	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	747,609	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	938	0	16,979	0	5,184,916	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	114	0	390	0	590,006	54.01
56.00	05600	RADIOISOTOPE	62	0	63,630	0	596,784	56.00
58.00	05800	MRI	6	0	3,134	0	982,303	58.00
60.00	06000	LABORATORY	1,212	0	291,951	0	6,363,503	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	41,929	0	62,742	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	7,059	0	474,520	64.00
66.00	06600	PHYSICAL THERAPY	672	0	0	0	1,422,740	66.00
67.00	06700	OCCUPATIONAL THERAPY	146	0	0	0	370,142	67.00
68.00	06800	SPEECH PATHOLOGY	7	0	0	0	13,729	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	1,064	0	23,871	0	1,364,397	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	270,150	0	743,354	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	357	0	0	0	838,675	73.00
76.00	03020	OP SENIOR HEALTH	447	9,307	0	0	903,049	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	13	0	0	0	43,000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,076	0	0	0	3,071,404	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	266,847	88.01
91.00	09100	EMERGENCY	2,696	13,322	0	0	2,278,025	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	5,566	0	1,688,493	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	1,072,430	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,161	75,394	725,584	0	32,138,501	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	82	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	368,445	366,637	142,387	0	402,784	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.868497	4.862947	0.196238	0.000000	0.012533	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	24,377	15,654	9,291	0	81,010	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.711507	0.207629	0.012805	0.000000	0.002521	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/9/2015 4:26 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING		1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00590	ADMINISTRATIVE AND GENERAL		5.01
5.02	00591	A&G HOSPITAL ONLY		5.02
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT-CLINIC		7.01
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
19.00	01900	NONPHYSICIAN ANESTHETISTS	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		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
54.01	05401	RADIOLOGY-ULTRASOUND	0	54.01
56.00	05600	RADIOISOTOPE	0	56.00
58.00	05800	MRI	0	58.00
60.00	06000	LABORATORY	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
69.01	03160	CARDIOPULMONARY	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03020	OP SENIOR HEALTH	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88.01
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
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
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	HOSPICE	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	194.01
194.02	07952	MEALS ON WHEELS	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST CENTERS	0	194.04
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	369,886	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,698.860000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,910	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	29.100000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/9/2015 4:26 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	2,786,084		2,786,084	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	696,719		696,719	0	0	50.00
53.00	05300	ANESTHESIOLOGY	379,821		379,821	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,280,983		1,280,983	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	180,244		180,244	0	0	54.01
56.00	05600	RADIOISOTOPE	207,986		207,986	0	0	56.00
58.00	05800	MRI	147,328		147,328	0	0	58.00
60.00	06000	LABORATORY	1,863,963		1,863,963	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	59,536		59,536	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	15,837		15,837	0	0	64.00
66.00	06600	PHYSICAL THERAPY	916,802	0	916,802	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	222,650	0	222,650	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,966	0	18,966	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	863,421		863,421	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	424,514		424,514	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	888,448		888,448	0	0	73.00
76.00	03020	OP SENIOR HEALTH	583,957		583,957	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	24,283		24,283	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,204,119		4,204,119	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	439,854		439,854	0	0	88.01
91.00	09100	EMERGENCY	2,717,719		2,717,719	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	355,680		355,680		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	569,536		569,536	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	852,527		852,527		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,700,977	0	20,700,977	0	0	200.00
201.00		Less Observation Beds	355,680		355,680		0	201.00
202.00		Total (see instructions)	20,345,297	0	20,345,297	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/9/2015 4:26 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,526,158		1,526,158			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	86,790	1,031,550	1,118,340	0.622994	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	56,997	690,612	747,609	0.508048	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	226,735	4,958,181	5,184,916	0.247060	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	43,996	546,010	590,006	0.305495	0.000000	54.01
56.00	05600	RADIOISOTOPE	17,795	578,989	596,784	0.348511	0.000000	56.00
58.00	05800	MRI	59,373	922,930	982,303	0.149982	0.000000	58.00
60.00	06000	LABORATORY	571,255	5,792,248	6,363,503	0.292915	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	27,374	35,368	62,742	0.948902	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	31,461	443,059	474,520	0.033375	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	195,329	1,227,411	1,422,740	0.644392	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,617	251,525	370,142	0.601526	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	6,763	6,966	13,729	1.381455	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	201,031	1,163,366	1,364,397	0.632822	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	240,518	502,836	743,354	0.571079	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	281,058	557,617	838,675	1.059347	0.000000	73.00
76.00	03020	OP SENIOR HEALTH	0	903,049	903,049	0.646650	0.000000	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	43,000	43,000	0.564721	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,071,404	3,071,404			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	266,847	266,847			88.01
91.00	09100	EMERGENCY	5,842	2,272,183	2,278,025	1.193015	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	415,335	415,335	0.856369	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,794	1,684,699	1,688,493	0.337304	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,072,430	1,072,430			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,700,886	28,437,615	32,138,501			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,700,886	28,437,615	32,138,501			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/9/2015 4:26 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
31.00	03100	INTENSIVE CARE UNIT			31.00
		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
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	03160	CARDIOPULMONARY	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	OP SENIOR HEALTH	0.000000		76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/9/2015 4:26 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	2,786,084		2,786,084	0	2,786,084	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	696,719		696,719	0	696,719	50.00
53.00	05300	ANESTHESIOLOGY	379,821		379,821	0	379,821	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,280,983		1,280,983	0	1,280,983	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	180,244		180,244	0	180,244	54.01
56.00	05600	RADIOISOTOPE	207,986		207,986	0	207,986	56.00
58.00	05800	MRI	147,328		147,328	0	147,328	58.00
60.00	06000	LABORATORY	1,863,963		1,863,963	0	1,863,963	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	59,536		59,536	0	59,536	62.00
64.00	06400	INTRAVENOUS THERAPY	15,837		15,837	0	15,837	64.00
66.00	06600	PHYSICAL THERAPY	916,802	0	916,802	0	916,802	66.00
67.00	06700	OCCUPATIONAL THERAPY	222,650	0	222,650	0	222,650	67.00
68.00	06800	SPEECH PATHOLOGY	18,966	0	18,966	0	18,966	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	863,421		863,421	0	863,421	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	424,514		424,514	0	424,514	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	888,448		888,448	0	888,448	73.00
76.00	03020	OP SENIOR HEALTH	583,957		583,957	0	583,957	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	24,283		24,283	0	24,283	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,204,119		4,204,119	0	4,204,119	88.00
88.01	08801	RURAL HEALTH CLINIC II	439,854		439,854	0	439,854	88.01
91.00	09100	EMERGENCY	2,717,719		2,717,719	0	2,717,719	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	355,680		355,680		355,680	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	569,536		569,536	0	569,536	95.00
101.00	10100	HOME HEALTH AGENCY	852,527		852,527		852,527	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,700,977	0	20,700,977	0	20,700,977	200.00
201.00		Less Observation Beds	355,680		355,680		355,680	201.00
202.00		Total (see instructions)	20,345,297	0	20,345,297	0	20,345,297	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/9/2015 4:26 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,526,158		1,526,158			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	86,790	1,031,550	1,118,340	0.622994	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	56,997	690,612	747,609	0.508048	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	226,735	4,958,181	5,184,916	0.247060	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	43,996	546,010	590,006	0.305495	0.000000	54.01
56.00	05600	RADIOISOTOPE	17,795	578,989	596,784	0.348511	0.000000	56.00
58.00	05800	MRI	59,373	922,930	982,303	0.149982	0.000000	58.00
60.00	06000	LABORATORY	571,255	5,792,248	6,363,503	0.292915	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	27,374	35,368	62,742	0.948902	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	31,461	443,059	474,520	0.033375	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	195,329	1,227,411	1,422,740	0.644392	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	118,617	251,525	370,142	0.601526	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	6,763	6,966	13,729	1.381455	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	201,031	1,163,366	1,364,397	0.632822	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	240,518	502,836	743,354	0.571079	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	281,058	557,617	838,675	1.059347	0.000000	73.00
76.00	03020	OP SENIOR HEALTH	0	903,049	903,049	0.646650	0.000000	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	43,000	43,000	0.564721	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,071,404	3,071,404	1.368794	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	266,847	266,847	1.648338	0.000000	88.01
91.00	09100	EMERGENCY	5,842	2,272,183	2,278,025	1.193015	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	415,335	415,335	0.856369	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,794	1,684,699	1,688,493	0.337304	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,072,430	1,072,430			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,700,886	28,437,615	32,138,501			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,700,886	28,437,615	32,138,501			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/9/2015 4:26 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
31.00	03100	INTENSIVE CARE UNIT			31.00
		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
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
69.01	03160	CARDIOPULMONARY	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	OP SENIOR HEALTH	0.000000		76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
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: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part II Date/Time Prepared: 2/9/2015 4:26 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	89,721	1,118,340	0.080227	59,083	4,740	50.00
53.00	05300	ANESTHESIOLOGY	1,890	747,609	0.002528	40,205	102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	262,726	5,184,916	0.050671	114,001	5,777	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	4,447	590,006	0.007537	22,666	171	54.01
56.00	05600	RADIOISOTOPE	6,954	596,784	0.011652	11,425	133	56.00
58.00	05800	MRI	3,582	982,303	0.003647	29,295	107	58.00
60.00	06000	LABORATORY	56,361	6,363,503	0.008857	303,126	2,685	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,093	62,742	0.017421	20,185	352	62.00
64.00	06400	INTRAVENOUS THERAPY	1,353	474,520	0.002851	14,109	40	64.00
66.00	06600	PHYSICAL THERAPY	98,119	1,422,740	0.068965	62,490	4,310	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,134	370,142	0.011169	35,371	395	67.00
68.00	06800	SPEECH PATHOLOGY	1,109	13,729	0.080778	298	24	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	55,868	1,364,397	0.040947	137,384	5,625	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	8,182	743,354	0.011007	137,544	1,514	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,561	838,675	0.017362	114,029	1,980	73.00
76.00	03020	OP SENIOR HEALTH	14,478	903,049	0.016032	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	315	43,000	0.007326	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	117,592	3,071,404	0.038286	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,698	266,847	0.017606	0	0	88.01
91.00	09100	EMERGENCY	62,406	2,278,025	0.027395	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	91,157	415,335	0.219478	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	900,746	27,851,420		1,101,211	27,955	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV Date/Time Prepared: 2/9/2015 4:26 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	369,886	0	0	0	369,886	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP SENIOR HEALTH	0	0	0	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	369,886	0	0	0	369,886	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV Date/Time Prepared: 2/9/2015 4:26 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	1,118,340	0.000000	0.000000	59,083	50.00
53.00	05300	ANESTHESIOLOGY	0	747,609	0.494759	0.000000	40,205	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,184,916	0.000000	0.000000	114,001	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	590,006	0.000000	0.000000	22,666	54.01
56.00	05600	RADIOISOTOPE	0	596,784	0.000000	0.000000	11,425	56.00
58.00	05800	MRI	0	982,303	0.000000	0.000000	29,295	58.00
60.00	06000	LABORATORY	0	6,363,503	0.000000	0.000000	303,126	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	62,742	0.000000	0.000000	20,185	62.00
64.00	06400	INTRAVENOUS THERAPY	0	474,520	0.000000	0.000000	14,109	64.00
66.00	06600	PHYSICAL THERAPY	0	1,422,740	0.000000	0.000000	62,490	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	370,142	0.000000	0.000000	35,371	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,729	0.000000	0.000000	298	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	03160	CARDIOPULMONARY	0	1,364,397	0.000000	0.000000	137,384	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	743,354	0.000000	0.000000	137,544	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	838,675	0.000000	0.000000	114,029	73.00
76.00	03020	OP SENIOR HEALTH	0	903,049	0.000000	0.000000	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	43,000	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,071,404	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	266,847	0.000000	0.000000	0	88.01
91.00	09100	EMERGENCY	0	2,278,025	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	415,335	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	27,851,420			1,101,211	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV Date/Time Prepared: 2/9/2015 4:26 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	19,892	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OP SENIOR HEALTH	0	0	0		76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	19,892	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/9/2015 4:26 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	0.622994	0	453,447	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.508048	0	305,195	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247060	0	2,033,843	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.305495	0	231,301	0	0	54.01
56.00	05600	RADIOISOTOPE	0.348511	0	248,598	0	0	56.00
58.00	05800	MRI	0.149982	0	359,679	0	0	58.00
60.00	06000	LABORATORY	0.292915	0	2,934,660	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.948902	0	20,634	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.033375	0	180,844	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.644392	0	538,032	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.601526	0	56,495	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.381455	0	2,763	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.632822	0	589,696	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.571079	0	206,848	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.059347	0	272,239	0	0	73.00
76.00	03020	OP SENIOR HEALTH	0.646650	0	903,049	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0.564721	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	1.193015	0	800,626	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.856369	0	94,916	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.337304		0			95.00
200.00		Subtotal (see instructions)		0	10,232,865	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	10,232,865	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/9/2015 4:26 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	282,495	0		50.00
53.00	05300	ANESTHESIOLOGY	155,054	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	502,481	0		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	70,661	0		54.01
56.00	05600	RADIOISOTOPE	86,639	0		56.00
58.00	05800	MRI	53,945	0		58.00
60.00	06000	LABORATORY	859,606	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	19,580	0		62.00
64.00	06400	INTRAVENOUS THERAPY	6,036	0		64.00
66.00	06600	PHYSICAL THERAPY	346,704	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	33,983	0		67.00
68.00	06800	SPEECH PATHOLOGY	3,817	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	373,173	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	118,127	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	288,396	0		73.00
76.00	03020	OP SENIOR HEALTH	583,957	0		76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	955,159	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	81,283	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	4,821,096	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,821,096	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141313 | Component CCN: 14Z313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/9/2015 4:26 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	0.622994	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.508048	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247060	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.305495	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.348511	0	0	0	0	56.00
58.00	05800	MRI	0.149982	0	0	0	0	58.00
60.00	06000	LABORATORY	0.292915	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.948902	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.033375	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.644392	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.601526	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.381455	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.632822	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.571079	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.059347	0	0	0	0	73.00
76.00	03020	OP SENIOR HEALTH	0.646650	0	0	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0.564721	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	1.193015	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.856369	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.337304		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141313 | Component CCN: 14Z313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V | Date/Time Prepared: 2/9/2015 4:26 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
54.01	05401	RADIOLOGY-ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OP SENIOR HEALTH	0	0		76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/9/2015 4:26 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)	1,284	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	839	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.	16	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	664	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	101	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)	303	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	10	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)	31	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	456	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)	101	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)	301	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)	13	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	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,786,084	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)	1,345	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)	4,171	25.00
26.00	Total swing-bed cost (see instructions)	909,256	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,876,828	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	940,521	28.00
29.00	Private room charges (excluding swing-bed charges)	26,713	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	913,808	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.995520	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	1,669.56	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,376.22	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	293.34	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	585.37	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	9,366	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,867,462	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)	2,225.82	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,014,974	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	7,610	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,022,584	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/9/2015 4:26 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	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	557,355	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,579,939	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)	224,808	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	669,972	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	894,780	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)	159	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,236.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	355,680	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/9/2015 4:26 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	481,013	1,876,828	0.256290	355,680	91,157	90.00
91.00	Nursing School cost	0	1,876,828	0.000000	355,680	0	91.00
92.00	Allied health cost	0	1,876,828	0.000000	355,680	0	92.00
93.00	All other Medical Education	0	1,876,828	0.000000	355,680	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/9/2015 4:26 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		736,772		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.622994	59,083	36,808	50.00
53.00	05300	ANESTHESIOLOGY	0.508048	40,205	20,426	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247060	114,001	28,165	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.305495	22,666	6,924	54.01
56.00	05600	RADIOISOTOPE	0.348511	11,425	3,982	56.00
58.00	05800	MRI	0.149982	29,295	4,394	58.00
60.00	06000	LABORATORY	0.292915	303,126	88,790	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.948902	20,185	19,154	62.00
64.00	06400	INTRAVENOUS THERAPY	0.033375	14,109	471	64.00
66.00	06600	PHYSICAL THERAPY	0.644392	62,490	40,268	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.601526	35,371	21,277	67.00
68.00	06800	SPEECH PATHOLOGY	1.381455	298	412	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.632822	137,384	86,940	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.571079	137,544	78,548	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.059347	114,029	120,796	73.00
76.00	03020	OP SENIOR HEALTH	0.646650	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0.564721	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	1.193015	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.856369	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,101,211	557,355	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,101,211		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141313 | Component CCN: 14Z313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/9/2015 4:26 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
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.622994	93	58	50.00
53.00	05300	ANESTHESIOLOGY	0.508048	26	13	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.247060	20,461	5,055	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.305495	2,928	894	54.01
56.00	05600	RADIOISOTOPE	0.348511	0	0	56.00
58.00	05800	MRI	0.149982	0	0	58.00
60.00	06000	LABORATORY	0.292915	83,157	24,358	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.948902	2,765	2,624	62.00
64.00	06400	INTRAVENOUS THERAPY	0.033375	6,811	227	64.00
66.00	06600	PHYSICAL THERAPY	0.644392	102,954	66,343	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.601526	66,236	39,843	67.00
68.00	06800	SPEECH PATHOLOGY	1.381455	6,440	8,897	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.632822	59,058	37,373	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.571079	47,359	27,046	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.059347	96,765	102,508	73.00
76.00	03020	OP SENIOR HEALTH	0.646650	0	0	76.00
76.01	03021	TELEMEDICINE-PSYCHIATRIC SERVICES	0.564721	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	1.193015	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.856369	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		495,053	315,239	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)		495,053		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141313	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 2/9/2015 4:26 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,821,096	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,821,096	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,869,307	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	39,955	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,458,235	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,371,117	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,371,117	30.00
31.00	Primary payer payments	2,881	31.00
32.00	Subtotal (line 30 minus line 31)	3,368,236	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)	371,193	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	282,107	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	337,534	36.00
37.00	Subtotal (see instructions)	3,650,343	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)	3,650,343	40.00
40.01	Sequestration adjustment (see instructions)	73,007	40.01
41.00	Interim payments	3,479,858	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	97,478	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I Date/Time Prepared: 2/9/2015 4:26 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		1,132,533		3,479,858	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	05/08/2014	61,500		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		61,500		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)		1,194,033		3,479,858	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		233,633		97,478	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,427,666		3,577,336	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: 141313 | Component CCN: 14Z313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 2/9/2015 4:26 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		937,457		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	05/08/2014	27,800		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		27,800		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)		965,257		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		225,658		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,190,915		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: 141313	Period: From 10/01/2013 To 09/30/2014	Worksheet E-1 Part II Date/Time Prepared: 2/9/2015 4:26 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	263	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	456	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	38	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	680	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	32,138,501	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	204,515	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	120,818	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	112,494	8.00
9.00	Sequestration adjustment amount (see instructions)	2,250	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	110,244	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	110,244	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141313 Component CCN: 14Z313	Period: From 10/01/2013 To 09/30/2014	Worksheet E-2 Date/Time Prepared: 2/9/2015 4:26 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)	903,728	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)	318,391	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	402	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,222,119	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,222,119	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,222,119	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,900	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)	1,215,219	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)	1,215,219	0	19.00
19.01	Sequestration adjustment (see instructions)	24,304	0	19.01
20.00	Interim payments	965,257	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	225,658	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: 141313	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part V Date/Time Prepared: 2/9/2015 4:26 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,579,939	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	1,579,939	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,595,738	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,595,738	19.00
20.00	Deductibles (exclude professional component)	169,280	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,426,458	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,426,458	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	39,926	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	30,344	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	39,926	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,456,802	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)	1,456,802	30.00
30.01	Sequestration adjustment (see instructions)	29,136	30.01
31.00	Interim payments	1,194,033	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	233,633	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G | Date/Time Prepared: 2/9/2015 4:26 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	2,632,266	0	0	0	1.00
2.00	Temporary investments	500,315	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,939,079	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	384,422	0	0	0	7.00
8.00	Prepaid expenses	140,802	0	0	0	8.00
9.00	Other current assets	338,294	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)	7,935,178	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	10,783,114	0	0	0	15.00
16.00	Accumulated depreciation	0	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	10,783,114	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,523,886	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	209,728	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,733,614	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	20,451,906	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,065,459	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,264,205	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	795,489	0	0	0	40.00
41.00	Deferred income	824,884	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	321,778	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,271,815	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,822,047	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	482,173	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	7,304,220	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	11,576,035	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	8,875,871				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)	8,875,871	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	20,451,906	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-1 | Date/Time Prepared: 2/9/2015 4:26 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		8,743,093		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		132,778				2.00
3.00	Total (sum of line 1 and line 2)		8,875,871		0		3.00
4.00	PY ADJUSTMENT	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)		8,875,871		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)		8,875,871		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	PY ADJUSTMENT		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: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/9/2015 4:26 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,942,762		1,942,762	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,942,762		1,942,762	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,942,762		1,942,762	17.00
18.00	Ancillary services	1	1	2	18.00
19.00	Outpatient services	0	1	1	19.00
20.00	RURAL HEALTH CLINIC	0	3,071,402	3,071,402	20.00
20.01	RURAL HEALTH CLINIC II	0	266,847	266,847	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,072,467	1,072,467	22.00
23.00	AMBULANCE SERVICES	3,793	1,699,961	1,703,754	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
27.01	OPERATING ROOM	128,275	1,262,188	1,390,463	27.01
27.02	ANESTHESIOLOGY	63,170	824,470	887,640	27.02
27.03	RADIOLOGY-DIAGNOSTIC	234,152	5,153,445	5,387,597	27.03
27.04	RADIOLOGY-ULTRASOUND	43,996	556,047	600,043	27.04
27.05	RADIOISOTOPE	17,795	594,347	612,142	27.05
27.06	MRI	59,373	990,186	1,049,559	27.06
27.07	LABORATORY	599,780	5,963,629	6,563,409	27.07
27.08	INTRAVENOUS THERAPY	55,973	475,895	531,868	27.08
27.09	PHYSICAL THERAPY	195,329	1,271,312	1,466,641	27.09
27.10	OCCUPATIONAL THERAPY	118,733	256,040	374,773	27.10
27.11	SPEECH PATHOLOGY	6,763	6,966	13,729	27.11
27.12	CARDIOPULMONARY	382,094	1,357,193	1,739,287	27.12
27.13	MEDICAL SUPPLIES CHARGED	44,181	175,789	219,970	27.13
27.14	DRUGS CHARGED TO PATIENTS	281,058	653,556	934,614	27.14
27.16	OP SENIOR PSYCH	0	903,049	903,049	27.16
27.17	TELEMEDICINE PSYCH	0	43,000	43,000	27.17
27.18	EMERGENCY	11,042	4,464,390	4,475,432	27.18
27.21	FITNESS CENTER	0	10,631	10,631	27.21
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,188,270	31,072,812	35,261,082	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,104,669		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	CONTRIBUTION EXP	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	EMPLOYEE PHYSICALS	2,966			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)		2,966		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		22,101,703		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-3 | Date/Time Prepared: 2/9/2015 4:26 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	35,261,082	1.00
2.00	Less contractual allowances and discounts on patients' accounts	12,887,581	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,373,501	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,101,703	4.00
5.00	Net income from service to patients (line 3 minus line 4)	271,798	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	117,399	6.00
7.00	Income from investments	100,154	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	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	870,664	23.00
24.00	OTHER REVENUE	459,726	24.00
24.01	GRANT REVENUE	128,623	24.01
24.02	ELECTRONIC HEALTH RECORDS INCENTIVE	271,620	24.02
24.03	LAB OUTREACH REV	48	24.03
25.00	Total other income (sum of lines 6-24)	1,948,234	25.00
26.00	Total (line 5 plus line 25)	2,220,032	26.00
27.00	BAD DEBTS	1,897,806	27.00
27.01	CHARITY CARE	189,348	27.01
27.02	ROUNDING	100	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	2,087,254	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	132,778	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141313 | HHA CCN: 147202 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H | Date/Time Prepared: 2/9/2015 4:26 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	108,329	7,754	29,752	0	35,712	181,547	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	384,318	27,509	0	0	0	411,827	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	54	4	0	0	0	58	10.00
11.00	Home Health Aide	12,690	908	0	0	0	13,598	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	505,391	36,175	29,752	0	35,712	607,030	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	181,547	0	181,547			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	411,827	0	411,827			6.00
7.00	Physical Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	58	0	58			10.00
11.00	Home Health Aide	0	13,598	0	13,598			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	607,030	0	607,030			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 141313 HHA CCN: 147202

Period: From 10/01/2013 To 09/30/2014

Worksheet H-1 Part I Date/Time Prepared: 2/9/2015 4:26 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	181,547	0	0	0	0	181,547	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	411,827	0	0	0	0	411,827	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	58	0	0	0	0	58	10.00
11.00	Home Health Aide	13,598	0	0	0	0	13,598	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	607,030	0	0	0	0	607,030	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	181,547		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	175,720	587,547	6.00
7.00	Physical Therapy	0	0	7.00
8.00	Occupational Therapy	0	0	8.00
9.00	Speech Pathology	0	0	9.00
10.00	Medical Social Services	25	83	10.00
11.00	Home Health Aide	5,802	19,400	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		607,030	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 141313 | HHA CCN: 147202 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-1 Part II Date/Time Prepared: 2/9/2015 4:26 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-181,547	425,483	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	411,827	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	58	10.00
11.00	Home Health Aide	0	0	0	0	0	13,598	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-181,547	425,483	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		181,547	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.426684	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141313 HHA CCN: 147202 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part I Date/Time Prepared: 2/9/2015 4:26 pm

Home Health Agency I | PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	1.01	1.02	2.00	4.00	
1.00	Administrative and General	0	0	7,934	0	6,454	82,368	1.00
2.00	Skilled Nursing Care	587,547	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	83	0	0	0	0	0	6.00
7.00	Home Health Aide	19,400	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	607,030	0	7,934	0	6,454	82,368	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		4A	5.01	5A.01	5.02	6.00	7.00	
1.00	Administrative and General	96,756	15,027	111,783	0	15,287	0	1.00
2.00	Skilled Nursing Care	587,547	91,248	678,795	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	83	13	96	0	0	0	6.00
7.00	Home Health Aide	19,400	3,013	22,413	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	703,786	109,301	813,087	0	15,287	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000		0.000000				21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141313 | HHA CCN: 147202 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part I | Date/Time Prepared: 2/9/2015 4:26 pm

Home Health Agency I | PPS

	Cost Center Description	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.01	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	18	10,694	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	18	10,694	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	19.00	24.00	25.00	
1.00	Administrative and General	0	0	13,441	0	151,223	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	678,795	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	96	0	6.00
7.00	Home Health Aide	0	0	0	0	22,413	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	13,441	0	852,527	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141313 HHA CCN: 147202 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part I Date/Time Prepared: 2/9/2015 4:26 pm

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	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		26.00	27.00	28.00			
1.00	Administrative and General	151,223					1.00
2.00	Skilled Nursing Care	678,795	146,369	825,164			2.00
3.00	Physical Therapy	0	0	0			3.00
4.00	Occupational Therapy	0	0	0			4.00
5.00	Speech Pathology	0	0	0			5.00
6.00	Medical Social Services	96	21	117			6.00
7.00	Home Health Aide	22,413	4,833	27,246			7.00
8.00	Supplies (see instructions)	0	0	0			8.00
9.00	Drugs	0	0	0			9.00
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0			15.00
16.00	Day Care Program	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0			17.00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	852,527	151,223	852,527			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.215631				21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141313 | HHA CCN: 147202 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part II | Date/Time Prepared: 2/9/2015 4:26 pm

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	Cost Center Description	CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	
		1.00	1.01	1.02	2.00	4.00	5A.01	
1.00	Administrative and General	0	1,594	0	6,456	505,391	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	1,594	0	6,456	505,391		20.00
21.00	Total cost to be allocated	0	7,934	0	6,454	82,368		21.00
22.00	Unit cost multiplier	0.000000	4.977415	0.000000	0.999690	0.162979		22.00

	Cost Center Description	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	
		5.01	5A.02	5.02	6.00	7.00	7.01	
1.00	Administrative and General	96,756	-111,783	0	1,594	0	0	1.00
2.00	Skilled Nursing Care	587,547	-678,795	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	83	-96	0	0	0	0	6.00
7.00	Home Health Aide	19,400	-22,413	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	703,786		0	1,594	0	0	20.00
21.00	Total cost to be allocated	109,301		0	15,287	0	0	21.00
22.00	Unit cost multiplier	0.155304		0.000000	9.590339	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141313 HHA CCN: 147202 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-2 Part II Date/Time Prepared: 2/9/2015 4:26 pm

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	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	10	1,594	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	10	1,594	0	0	0	0	20.00
21.00	Total cost to be allocated	18	10,694	0	0	0	0	21.00
22.00	Unit cost multiplier	1.800000	6.708908	0.000000	0.000000	0.000000	0.000000	22.00

	Cost Center Description	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)				
		15.00	16.00	19.00				
1.00	Administrative and General	0	1,072,430	0				1.00
2.00	Skilled Nursing Care	0	0	0				2.00
3.00	Physical Therapy	0	0	0				3.00
4.00	Occupational Therapy	0	0	0				4.00
5.00	Speech Pathology	0	0	0				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	0	0	0				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
20.00	Total (sum of lines 1-19)	0	1,072,430	0				20.00
21.00	Total cost to be allocated	0	13,441	0				21.00
22.00	Unit cost multiplier	0.000000	0.012533	0.000000				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 141313 HHA CCN: 147202 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-3 Part I Date/Time Prepared: 2/9/2015 4:26 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	825,164		825,164	18,798	43.90	1.00
2.00	Physical Therapy	3.00	0	155,907	155,907	2,547	61.21	2.00
3.00	Occupational Therapy	4.00	0	47,821	47,821	947	50.50	3.00
4.00	Speech Pathology	5.00	0	8,420	8,420	76	110.79	4.00
5.00	Medical Social Services	6.00	117		117	36	3.25	5.00
6.00	Home Health Aide	7.00	27,246		27,246	694	39.26	6.00
7.00	Total (sum of lines 1-6)		852,527	212,148	1,064,675	23,098		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	192	2,105			8.00
8.01	Skilled Nursing Care		99915	0	6			8.01
9.00	Physical Therapy		99914	62	597			9.00
9.01	Physical Therapy		99915	0	13			9.01
10.00	Occupational Therapy		99914	41	219			10.00
10.01	Occupational Therapy		99915	0	3			10.01
11.00	Speech Pathology		99914	3	7			11.00
11.01	Speech Pathology		99915	0	0			11.01
12.00	Medical Social Services		99914	0	6			12.00
12.01	Medical Social Services		99915	0	0			12.01
13.00	Home Health Aide		99914	18	184			13.00
13.01	Home Health Aide		99915	0	0			13.01
14.00	Total (sum of lines 8-13)			316	3,140			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	5,527	5,527	9,678	0.571089	15.00
16.00	Cost of Drugs	9.00	0	479	479	452	1.059735	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	192	2,111		8,429	92,673		1.00
2.00	Physical Therapy	62	610		3,795	37,338		2.00
3.00	Occupational Therapy	41	222		2,071	11,211		3.00
4.00	Speech Pathology	3	7		332	776		4.00
5.00	Medical Social Services	0	6		0	20		5.00
6.00	Home Health Aide	18	184		707	7,224		6.00
7.00	Total (sum of lines 1-6)	316	3,140		15,334	149,242		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141313 | HHA CCN: 147202 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-3 Part I | Date/Time Prepared: 2/9/2015 4:26 pm

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies							15.00
16.00	Cost of Drugs		241	0		255	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	101,102						1.00
2.00	Physical Therapy	41,133						2.00
3.00	Occupational Therapy	13,282						3.00
4.00	Speech Pathology	1,108						4.00
5.00	Medical Social Services	20						5.00
6.00	Home Health Aide	7,931						6.00
7.00	Total (sum of lines 1-6)	164,576						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141313 HHA CCN: 147202 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-3 Part II Date/Time Prepared: 2/9/2015 4:26 pm

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.644392	241,945	155,907	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.601526	79,500	47,821	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	1.381455	6,095	8,420	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.571079	9,678	5,527	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	1.059347	452	479	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141313 | HHA CCN: 147202 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/9/2015 4:26 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	255	0	1.00
2.00	Total charges	0	254	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	254	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	1	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	255	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	31,782	366,722	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	3,522	17,679	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	5,263	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	3,046	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	35,304	392,965	22.00
23.00	Excess reasonable cost (from line 8)	0	1	23.00
24.00	Subtotal (line 22 minus line 23)	35,304	392,964	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	35,304	392,964	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	35,304	392,964	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	35,304	392,964	31.00
31.01	Sequestration adjustment (see instructions)	631	7,974	31.01
32.00	Interim payments (see instructions)	34,673	384,990	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	35.00

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

Provider CCN: 141313 HHA CCN: 147202 | Period: From 10/01/2013 To 09/30/2014 | Worksheet H-5 | Date/Time Prepared: 2/9/2015 4:26 pm

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		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		34,673		384,990	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		34,673		384,990	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		34,673		384,990	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

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

Provider CCN: 141313 Component CCN: 143457 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/9/2015 4:26 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	1,344,262	0	1,344,262	-89,341	1,254,921	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	290,777	0	290,777	0	290,777	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	429,683	0	429,683	0	429,683	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)	2,064,722	0	2,064,722	-89,341	1,975,381	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	13,324	13,324	0	13,324	13.00
14.00	Subtotal (sum of lines 11-13)	0	13,324	13,324	0	13,324	14.00
15.00	Medical Supplies	0	10,643	10,643	0	10,643	15.00
16.00	Transportation (Health Care Staff)	0	564	564	0	564	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	59,972	59,972	0	59,972	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	71,179	71,179	0	71,179	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,064,722	84,503	2,149,225	-89,341	2,059,884	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	289	289	0	289	29.00
30.00	Administrative Costs	365,370	444,790	810,160	0	810,160	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	365,370	445,079	810,449	0	810,449	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,430,092	529,582	2,959,674	-89,341	2,870,333	32.00

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

Provider CCN: 141313 | Component CCN: 143457 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/9/2015 4:26 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,254,921		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	290,777		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	429,683		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	1,975,381		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	13,324		13.00
14.00	Subtotal (sum of lines 11-13)	0	13,324		14.00
15.00	Medical Supplies	0	10,643		15.00
16.00	Transportation (Health Care Staff)	0	564		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	59,972		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	71,179		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,059,884		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	289		29.00
30.00	Administrative Costs	-75	810,085		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-75	810,374		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-75	2,870,258		32.00

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

Provider CCN: 141313 Component CCN: 143462 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/9/2015 4:26 pm

Rural Health Clinic (RHC) II | 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	55,411	0	55,411	0	55,411	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	108,560	0	108,560	0	108,560	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	52,080	0	52,080	0	52,080	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)	216,051	0	216,051	0	216,051	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	1,918	1,918	0	1,918	13.00
14.00	Subtotal (sum of lines 11-13)	0	1,918	1,918	0	1,918	14.00
15.00	Medical Supplies	0	771	771	0	771	15.00
16.00	Transportation (Health Care Staff)	0	7,554	7,554	0	7,554	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	8,325	8,325	0	8,325	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	216,051	10,243	226,294	0	226,294	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	6,490	6,490	0	6,490	29.00
30.00	Administrative Costs	41,821	59,466	101,287	0	101,287	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	41,821	65,956	107,777	0	107,777	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	257,872	76,199	334,071	0	334,071	32.00

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

Provider CCN: 141313 | Component CCN: 143462 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/9/2015 4:26 pm

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	55,411		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	108,560		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	52,080		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	216,051		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	1,918		13.00
14.00	Subtotal (sum of lines 11-13)	0	1,918		14.00
15.00	Medical Supplies	0	771		15.00
16.00	Transportation (Health Care Staff)	0	7,554		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	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	8,325		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	226,294		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	6,490		29.00
30.00	Administrative Costs	-75	101,212		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-75	107,702		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-75	333,996		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-2

Component CCN: 143457 | Date/Time Prepared: 2/9/2015 4:26 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	1.75	9,210	4,200	7,350		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.36	4,470	2,100	2,856		3.00
4.00	Subtotal (sum of lines 1-3)	3.11	13,680		10,206	13,680	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	3.11	13,680			13,680	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)					2,059,884	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)					2,059,884	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)					810,374	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,333,861	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,144,235	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					2,144,235	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					2,144,235	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					4,204,119	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141313 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-2

Component CCN: 143462 | Date/Time Prepared: 2/9/2015 4:26 pm

Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.22	656	4,200	924		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.42	1,003	2,100	882		3.00
4.00	Subtotal (sum of lines 1-3)	0.64	1,659		1,806	1,806	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)	0.64	1,659			1,806	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)					226,294	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)					226,294	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)					107,702	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					105,858	15.00
16.00	Total overhead (sum of lines 14 and 15)					213,560	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					213,560	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					213,560	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					439,854	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2013 To 09/30/2014	Worksheet M-3 Date/Time Prepared: 2/9/2015 4:26 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)		4,204,119	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		103,245	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		4,100,874	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		13,680	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)		13,680	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		299.77	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)	299.77	299.77	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,785	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,434,399	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	16	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	4,796	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	4,796	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) *		1,439,195	16.00
16.01	Total program charges (see instructions)(from contractor's records)		772,824	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,258	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		15,378	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.)		1,077,070	16.04
16.05	Total program cost (see instructions)		1,092,448	16.05
17.00	Primary payer amounts		133	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		77,479	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		137,523	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,092,315	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		55,826	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,148,141	22.00
23.00	Allowable bad debts (see instructions)		34,373	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		26,123	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		34,373	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		1,174,264	26.00
26.01	Sequestration adjustment (see instructions)		23,485	26.01
27.00	Interim payments		794,422	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		356,357	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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2013 To 09/30/2014	Worksheet M-3 Date/Time Prepared: 2/9/2015 4:26 pm
	Title XVIII	Rural Health Clinic (RHC) II	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)		439,854	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		1,553	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		438,301	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		1,806	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)		1,806	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		242.69	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)	242.69	242.69	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	245	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	59,459	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) *		59,459	16.00
16.01	Total program charges (see instructions)(from contractor's records)		39,571	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		612	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		920	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.)		42,262	16.04
16.05	Total program cost (see instructions)		43,182	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,711	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		6,650	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		43,182	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,046	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		44,228	22.00
23.00	Allowable bad debts (see instructions)		1,231	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		936	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,231	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		45,164	26.00
26.01	Sequestration adjustment (see instructions)		903	26.01
27.00	Interim payments		14,551	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		29,710	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: 141313 Component CCN: 143457	Period: From 10/01/2013 To 09/30/2014	Worksheet M-4 Date/Time Prepared: 2/9/2015 4:26 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	1,975,381	1,975,381	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002834	0.017868	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	5,598	35,296	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,820	4,872	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	10,418	40,168	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	2,059,884	2,059,884	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	2,144,235	2,144,235	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.005058	0.019500	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	10,846	41,813	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	21,264	81,981	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	69	435	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	308.17	188.46	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	46	221	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	14,176	41,650	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)		103,245	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)		55,826	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2013 To 09/30/2014	Worksheet M-4 Date/Time Prepared: 2/9/2015 4:26 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	216,051	216,051	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000123	0.001150	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	27	248	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	210	314	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	237	562	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	226,294	226,294	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	213,560	213,560	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001047	0.002483	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	224	530	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	461	1,092	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	3	28	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	153.67	39.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	3	15	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	461	585	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)		1,553	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		1,046	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2013 To 09/30/2014	Worksheet M-5 Date/Time Prepared: 2/9/2015 4:26 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		763,322	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		05/08/2014	31,100	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		31,100	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		794,422	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		356,357	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,150,779	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2013 To 09/30/2014	Worksheet M-5 Date/Time Prepared: 2/9/2015 4:26 pm
		Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		14,551	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			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		14,551	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		29,710	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		44,261	7.00

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