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: 141325	Period: From 04/01/2014 To 09/30/2014	Worksheet S Parts I-III Date/Time Prepared: 2/26/2015 9:48 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: — Time:
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 OSF SAINT LUKE MEDICAL CENTER (141325) for the cost reporting period beginning 04/01/2014 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	661,109	239,578	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVIDER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	94,499	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		76,569		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	755,608	316,147	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2015 9:48 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1051 WEST SOUTH STREET	PO Box: 747			1.00
2.00	City: KEWANEE	State: IL	Zip Code: 61443	County: HENRY	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	OSF SAINT LUKE MEDICAL CENTER	141325	99914	1	07/01/1966	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	OSF SAINT LUKE SWING BED	14Z325	99914		03/19/2003	N	O	N	7.00
8.00	Swing Beds - NF	OSF SAINT LUKE SWING BED	14Z325	99914		03/19/2003	N		N	8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FAMILY HEALTH CLINIC	143445	99914		10/01/1998	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2014	09/30/2014	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0	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: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2015 9:48 am

		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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/26/2015 9:48 am

		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: 141325	Period: From 04/01/2014 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 2/26/2015 9:48 am

		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.	N		108.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	64,912	0	0	118.01

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

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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)	Y	149006	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: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS	Contractor's Number: 00131	141.00
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:		142.00
143.00	City: PEORIA	State: IL	Zip Code: 61603	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	Y	Y	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)	172,852	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)	04/01/2014	09/30/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2015 9:48 am

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	Y	03/31/2014	1.00

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

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

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

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	Y	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	12/02/2014	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 2/26/2015 9:48 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	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.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CAROLE	WAHL	41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF HEALTHCARE SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	309.655.2855	CAROLE.M.WAHL@OSFHEALTHCARE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 2/26/2015 9:48 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				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)	12/02/2014			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		GOVT REPORTING SENIOR ANALYST		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

HFS Supplemental Information | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet S-2 Part IX Date/Time Prepared: 2/26/2015 9:48 am

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 2/26/2015 9:48 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	4,026	13,824.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		22	4,026	13,824.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	3	549	648.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	4,575	14,472.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	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: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2015 9:48 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	361	78	576			1.00
2.00	HMO and other (see instructions)	2	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	44	0	139			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		14	14			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	405	92	729			7.00
8.00	INTENSIVE CARE UNIT	12	5	27			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		0	0			13.00
14.00	Total (see instructions)	417	97	756	0.00	187.82	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER	0	0	0	0.00	0.00	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						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	828	2,302	6,115	0.00	19.17	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	206.99	27.00
28.00	Observation Bed Days		47	264			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2015 9:48 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	147	36	242	1.00
2.00	HMO and other (see instructions)			1	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	147	36	242	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00	SUBPROVIDER	0.00	0	0	0	0	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						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141325
Component CCN: 143445

Period:
From 04/01/2014
To 09/30/2014

Worksheet S-8

Date/Time Prepared:
2/26/2015 9:48 am

		Rural Health Clinic (RHC) I	Cost	
		1.00		
	Clinic Address and Identification			
1.00	Street	1051 WEST SOUTH STREET		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	KEWANEE	IL	61443 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	18:00	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		HENRY				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	18:00	08:00	18:00	08:00	18:00	11.00

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

Provider CCN: 141325
Component CCN: 143445

Period:
From 04/01/2014
To 09/30/2014

Worksheet S-8

Date/Time Prepared:
2/26/2015 9:48 am

Rural Health Clinic (RHC) I

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet S-10 | Date/Time Prepared: 2/26/2015 9:48 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.508844	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,134,649	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,079,017	5.00
6.00	Medicaid charges	9,364,327	6.00
7.00	Medicaid cost (line 1 times line 6)	4,764,982	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)	2,551,316	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,551,316	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	725,340	75,840	801,180	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	369,085	38,591	407,676	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)	369,085	38,591	407,676	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)	1,076,956	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	165,135	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	911,821	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	463,975	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	871,651	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,422,967	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/26/2015 9:48 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,573,531	1,573,531	0	1,573,531	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		842,246	842,246	0	842,246	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	81,165	1,439,773	1,520,938	0	1,520,938	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	817,928	1,638,623	2,456,551	-29,337	2,427,214	5.00
7.00	00700	OPERATION OF PLANT	148,599	415,211	563,810	0	563,810	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	64,634	64,634	0	64,634	8.00
9.00	00900	HOUSEKEEPING	111,844	16,569	128,413	0	128,413	9.00
10.00	01000	DIETARY	124,150	78,421	202,571	-150,351	52,220	10.00
11.00	01100	CAFETERIA	0	0	0	150,351	150,351	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26,663	6,816	33,479	0	33,479	14.00
15.00	01500	PHARMACY	90,896	194,779	285,675	0	285,675	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	77,660	26,052	103,712	0	103,712	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	826,161	90,596	916,757	-4,235	912,522	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	33,373	33,373	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	255,133	267,951	523,084	147,463	670,547	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	192,009	28,966	220,975	0	220,975	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	395,942	668,574	1,064,516	-658,717	405,799	54.00
56.00	05600	RADIOISOTOPE	0	0	0	121,143	121,143	56.00
56.01	03630	ULTRA SOUND	0	0	0	74,544	74,544	56.01
57.00	05700	CT SCAN	0	0	0	157,040	157,040	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	268,500	268,500	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	276,299	443,325	719,624	-22,976	696,648	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	22,976	22,976	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	81,500	81,500	65.00
66.00	06600	PHYSICAL THERAPY	330,038	23,178	353,216	0	353,216	66.00
67.00	06700	OCCUPATIONAL THERAPY	94,897	4,112	99,009	0	99,009	67.00
68.00	06800	SPEECH PATHOLOGY	47,511	2,646	50,157	0	50,157	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	147,530	31,528	179,058	-81,500	97,558	69.01
69.02	03650	VASCULAR LAB	0	0	0	37,490	37,490	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	13,463	13,463	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	716,504	220,430	936,934	-160,926	776,008	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	405,305	1,088,905	1,494,210	199	1,494,409	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,166,234	9,166,866	14,333,100	0	14,333,100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,334	7,546	10,880	0	10,880	190.00
190.01	19001	FOUNDATION	22,062	154	22,216	0	22,216	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	16,745	16,745	0	16,745	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,596	5,596	0	5,596	192.00
200.00		TOTAL (SUM OF LINES 118-199)	5,191,630	9,196,907	14,388,537	0	14,388,537	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/26/2015 9:48 am

		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	2,687,439	4,260,970		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-271,465	570,781		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-209	1,520,729		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	291,978	2,719,192		5.00
7.00	00700	OPERATION OF PLANT	0	563,810		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	64,634		8.00
9.00	00900	HOUSEKEEPING	0	128,413		9.00
10.00	01000	DIETARY	0	52,220		10.00
11.00	01100	CAFETERIA	-68,061	82,290		11.00
13.00	01300	NURSING ADMINISTRATION	0	0		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	33,479		14.00
15.00	01500	PHARMACY	0	285,675		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,677	101,035		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-338,421	574,101		30.00
31.00	03100	INTENSIVE CARE UNIT	0	33,373		31.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-160,926	509,621		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	-192,009	28,966		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-28,348	377,451		54.00
56.00	05600	RADIOISOTOPE	0	121,143		56.00
56.01	03630	ULTRA SOUND	0	74,544		56.01
57.00	05700	CT SCAN	0	157,040		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	268,500		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-15,502	681,146		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	22,976		62.00
65.00	06500	RESPIRATORY THERAPY	2,647	84,147		65.00
66.00	06600	PHYSICAL THERAPY	-2,474	350,742		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	99,009		67.00
68.00	06800	SPEECH PATHOLOGY	0	50,157		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	97,558		69.01
69.02	03650	VASCULAR LAB	0	37,490		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	13,463		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-12,707	-12,707		73.00
73.01	03480	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-56,289	719,719		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	-736,752	757,657		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,096,224	15,429,324		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,880		190.00
190.01	19001	FOUNDATION	0	22,216		190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	16,745		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,596		192.00
200.00		TOTAL (SUM OF LINES 118-199)	1,096,224	15,484,761		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet Non-CMS W | Date/Time Prepared: 2/26/2015 9:48 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
41.00	SUBPROVIDER - IRF	04100		41.00
42.00	SUBPROVIDER	04200		42.00
43.00	NURSERY	04300		43.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
56.00	RADIOISOTOPE	05600		56.00
56.01	ULTRA SOUND	03630		56.01
57.00	CT SCAN	05700		57.00
58.00	MAGNETIC RESONANCE IMAGING (MRI)	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
60.01	BLOOD LABORATORY	06001		60.01
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	06200		62.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
69.01	CARDIOPULMONARY	03160		69.01
69.02	VASCULAR LAB	03650		69.02
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
73.01	ONCOLOGY	03480		73.01
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
190.01	FOUNDATION	19001		190.01
190.02	DURABLE MEDICAL EQUIP-RENTED	19002		190.02
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/26/2015 9:48 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	C - CAFETERIA					
1.00	CAFETERIA	11.00	92,146	58,205		1.00
	TOTALS		92,146	58,205		
	D - BLOOD COSTS					
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	2,827	20,149		1.00
	TOTALS		2,827	20,149		
	E - RESPIRATORY THERAPY					
1.00	RESPIRATORY THERAPY	65.00	67,150	14,350		1.00
	TOTALS		67,150	14,350		
	F - RADIOLOGY SERVICES					
1.00	RADIOISOTOPE	56.00	0	121,143		1.00
2.00	CT SCAN	57.00	92,246	64,794		2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	268,500		3.00
4.00	VASCULAR LAB	69.02	37,490	0		4.00
5.00	ULTRA SOUND	56.01	74,544	0		5.00
	TOTALS		204,280	454,437		
	I - CASE MANAGER/DIR NRS					
1.00	ADULTS & PEDIATRICS	30.00	28,507	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	631	0		2.00
3.00	EMERGENCY	91.00	199	0		3.00
	TOTALS		29,337	0		
	J - SURGEON RHC					
1.00	OPERATING ROOM	50.00	147,809	0		1.00
	TOTALS		147,809	0		
	K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	13,463		1.00
	TOTALS		0	13,463		
	L - ICU COSTS					
1.00	INTENSIVE CARE UNIT	31.00	29,506	3,236		1.00
	TOTALS		29,506	3,236		
	M - UROLOGY IN RHC					
1.00	OPERATING ROOM	50.00	0	13,117		1.00
	TOTALS		0	13,117		
500.00	Grand Total: Increases		573,055	576,957		500.00

RECLASSIFICATIONS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/26/2015 9:48 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	C - CAFETERIA						
1.00	DIETARY	10.00	92,146	58,205	0		1.00
	TOTALS		92,146	58,205			
	D - BLOOD COSTS						
1.00	LABORATORY	60.00	2,827	20,149	0		1.00
	TOTALS		2,827	20,149			
	E - RESPIRATORY THERAPY						
1.00	CARDIOPULMONARY	69.01	67,150	14,350	0		1.00
	TOTALS		67,150	14,350			
	F - RADIOLOGY SERVICES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	204,280	454,437	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
	TOTALS		204,280	454,437			
	I - CASE MANAGER/DIR NRS						
1.00	ADMINISTRATIVE & GENERAL	5.00	29,337	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		29,337	0			
	J - SURGEON RHC						
1.00	RURAL HEALTH CLINIC	88.00	147,809	0	0		1.00
	TOTALS		147,809	0			
	K - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	13,463	0		1.00
	TOTALS		0	13,463			
	L - ICU COSTS						
1.00	ADULTS & PEDIATRICS	30.00	29,506	3,236	0		1.00
	TOTALS		29,506	3,236			
	M - UROLOGY IN RHC						
1.00	RURAL HEALTH CLINIC	88.00	0	13,117	0		1.00
	TOTALS		0	13,117			
500.00	Grand Total: Decreases		573,055	576,957			500.00

RECLASSIFICATIONS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 2/26/2015 9:48 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	C - CAFETERIA								
1.00	CAFETERIA	11.00	92,146	58,205	DIETARY	10.00	92,146	58,205	1.00
	TOTALS		92,146	58,205	TOTALS		92,146	58,205	
	D - BLOOD COSTS								
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	2,827	20,149	LABORATORY	60.00	2,827	20,149	1.00
	TOTALS		2,827	20,149	TOTALS		2,827	20,149	
	E - RESPIRATORY THERAPY								
1.00	RESPIRATORY THERAPY	65.00	67,150	14,350	CARDIOPULMONARY	69.01	67,150	14,350	1.00
	TOTALS		67,150	14,350	TOTALS		67,150	14,350	
	F - RADIOLOGY SERVICES								
1.00	RADIOISOTOPE	56.00	0	121,143	RADIOLOGY-DIAGNOSTIC	54.00	204,280	454,437	1.00
2.00	CT SCAN	57.00	92,246	64,794		0.00	0	0	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	268,500		0.00	0	0	3.00
4.00	VASCULAR LAB	69.02	37,490	0		0.00	0	0	4.00
5.00	ULTRA SOUND	56.01	74,544	0		0.00	0	0	5.00
	TOTALS		204,280	454,437	TOTALS		204,280	454,437	
	I - CASE MANAGER/DIR NRS								
1.00	ADULTS & PEDIATRICS	30.00	28,507	0	ADMINISTRATIVE & GENERAL	5.00	29,337	0	1.00
2.00	INTENSIVE CARE UNIT	31.00	631	0		0.00	0	0	2.00
3.00	EMERGENCY	91.00	199	0		0.00	0	0	3.00
	TOTALS		29,337	0	TOTALS		29,337	0	
	J - SURGEON RHC								
1.00	OPERATING ROOM	50.00	147,809	0	RURAL HEALTH CLINIC	88.00	147,809	0	1.00
	TOTALS		147,809	0	TOTALS		147,809	0	
	K - IMPLANTABLE DEVICES								
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	13,463	OPERATING ROOM	50.00	0	13,463	1.00
	TOTALS		0	13,463	TOTALS		0	13,463	
	L - ICU COSTS								
1.00	INTENSIVE CARE UNIT	31.00	29,506	3,236	ADULTS & PEDIATRICS	30.00	29,506	3,236	1.00
	TOTALS		29,506	3,236	TOTALS		29,506	3,236	
	M - UROLOGY IN RHC								
1.00	OPERATING ROOM	50.00	0	13,117	RURAL HEALTH CLINIC	88.00	0	13,117	1.00
	TOTALS		0	13,117	TOTALS		0	13,117	
500.00	Grand Total: Increases		573,055	576,957	Grand Total: Decreases		573,055	576,957	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 2/26/2015 9:48 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	588,318	0	0	0	0	1.00
2.00	Land Improvements	854,467	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,781,051	417,844	0	417,844	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	21,677,556	0	0	0	285,956	6.00
7.00	HIT designated Assets	2,966,178	172,852	0	172,852	0	7.00
8.00	Subtotal (sum of lines 1-7)	45,867,570	590,696	0	590,696	285,956	8.00
9.00	Reconciling Items	0	5,781	0	5,781	0	9.00
10.00	Total (line 8 minus line 9)	45,867,570	584,915	0	584,915	285,956	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	588,318	0	1.00
2.00	Land Improvements	854,467	0	2.00
3.00	Buildings and Fixtures	20,198,895	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	21,391,600	0	6.00
7.00	HIT designated Assets	3,139,030	0	7.00
8.00	Subtotal (sum of lines 1-7)	46,172,310	0	8.00
9.00	Reconciling Items	5,781	0	9.00
10.00	Total (line 8 minus line 9)	46,166,529	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 2/26/2015 9:48 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	256,666	0	1,316,865	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	842,246	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,098,912	0	1,316,865	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	1,573,531		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	842,246		2.00
3.00	Total (sum of lines 1-2)	0	2,415,777		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 2/26/2015 9:48 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	21,053,362	0	21,053,362	0.461917	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	24,524,849	0	24,524,849	0.538083	0	2.00
3.00	Total (sum of lines 1-2)	45,578,211	0	45,578,211	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	463,583	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	570,781	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,034,364	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	3,797,387	0	0	0	4,260,970	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	570,781	2.00
3.00	Total (sum of lines 1-2)	3,797,387	0	0	0	4,831,751	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/26/2015 9:48 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-224,694	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		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	-1,252,147			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	3,463,042			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-68,061	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,677	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-251,399	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MAT MGMT OPERATIONS	B	7	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	HEALTH PROFESSIONAL ED REVENUE	B	-9,595	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/26/2015 9:48 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	OTHER REVENUE	B	-935	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	OTHER REVENUE - PT	B	-2,474	PHYSICAL THERAPY	66.00	0	33.03
33.04	OTHER REVENUE - PHARM	B	-4,983	DRUGS CHARGED TO PATIENTS	73.00	0	33.04
33.05	OTHER REVENUE - MED STAFF	B	-2,550	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MISC NONOP REV	B	-200	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	OTHER REVENUE	B	-7,724	DRUGS CHARGED TO PATIENTS	73.00	0	33.07
33.08	RENTAL/LEASE EQUPMENT	B	2,647	RESPIRATORY THERAPY	65.00	0	33.08
33.09	PROVIDER TAX	A	-370,261	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	PATIENT PHONE - SALARIES	A	-771	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	PATIENT PHONE - BENEF	A	-209	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	PATIENT PHONE OTHER	A	-477	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	PATIENT PHONE DEPREC	A	-190	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.13
33.14	LOBBYING	A	-11,200	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15	CRNA	A	-192,009	ANESTHESIOLOGY	53.00	0	33.15
33.16	IMPAIRMENT OF ASSETS	A	206,917	CAP REL COSTS-BLDG & FIXT	1.00	9	33.16
33.17	IMPAIRMENT OF ASSETS	A	-19,100	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.17
33.18	LOSS ON EXT OF DEBT	A	-10,892	CAP REL COSTS-BLDG & FIXT	1.00	11	33.18
33.19	PATEINT TV	A	-776	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.19
33.20	MARKETING COSTS	A	-58,974	ADMINISTRATIVE & GENERAL	5.00	0	33.20
33.21	DEVELOPMENT COSTS	A	-14,208	EMERGENCY	91.00	0	33.21
33.22	PHYSICIAN RECRUITMENT	A	-2,251	RURAL HEALTH CLINIC	88.00	0	33.22
33.23	PATIENT TRANSPORTATION	A	-67,632	EMERGENCY	91.00	0	33.23
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1,096,224				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet A-8-1 | Date/Time Prepared: 2/26/2015 9:48 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST	0	99,146	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	CORPORATE ALLOCATIONS	0	422,811	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	INTEREST EXPENSE	2,815,254	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	NEW BLDG EXPENSE	37,049	0	4.00
4.01	5.00	ADMINISTRATIVE & GENERAL	NEW MME EXPENSE	310,413	0	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	NONCAPITAL EXPENSE	822,283	0	4.02
4.03	0.00			0	0	4.03
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,984,999	521,957	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B		0.00	OSF HEALTHCARE	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141325	Period: From 04/01/2014 To 09/30/2014	Worksheet A-8-1 Date/Time Prepared: 2/26/2015 9:48 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-99,146	11		1.00
2.00	-422,811	0		2.00
3.00	2,815,254	11		3.00
4.00	37,049	0		4.00
4.01	310,413	0		4.01
4.02	822,283	0		4.02
4.03	0	0		4.03
5.00	3,463,042			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2015 9:48 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	8,200	8,200	0	0	0	1.00
2.00	91.00	EMERGENCY	813,554	654,912	158,642	0	0	2.00
3.00	60.00	LABORATORY	15,502	15,502	0	0	0	3.00
4.00	88.00	RURAL HEALTH CLINIC	54,038	54,038	0	0	0	4.00
5.00	50.00	OPERATING ROOM	13,117	13,117	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	330,221	330,221	0	0	0	6.00
7.00	50.00	OPERATING ROOM	147,809	147,809	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	28,348	28,348	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			1,410,789	1,252,147	158,642		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	6.00
7.00	50.00	OPERATING ROOM	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	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	30.00	ADULTS & PEDIATRICS	0	0	0	8,200		1.00
2.00	91.00	EMERGENCY	0	0	0	654,912		2.00
3.00	60.00	LABORATORY	0	0	0	15,502		3.00
4.00	88.00	RURAL HEALTH CLINIC	0	0	0	54,038		4.00
5.00	50.00	OPERATING ROOM	0	0	0	13,117		5.00
6.00	30.00	ADULTS & PEDIATRICS	0	0	0	330,221		6.00
7.00	50.00	OPERATING ROOM	0	0	0	147,809		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	28,348		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,252,147		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet B Part I Date/Time Prepared: 2/26/2015 9:48 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,260,970	4,260,970				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	570,781		570,781			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,520,729	19,229	644	1,540,602		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,719,192	674,858	105,585	237,729	3,737,364	5.00
7.00	00700	OPERATION OF PLANT	563,810	359,376	17,928	44,797	985,911	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	64,634	18,300	0	0	82,934	8.00
9.00	00900	HOUSEKEEPING	128,413	35,186	603	33,716	197,918	9.00
10.00	01000	DIETARY	52,220	97,955	6,891	9,648	166,714	10.00
11.00	01100	CAFETERIA	82,290	33,418	0	27,778	143,486	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,731	0	0	12,731	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	33,479	0	7,253	8,038	48,770	14.00
15.00	01500	PHARMACY	285,675	60,161	3,418	27,402	376,656	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	101,035	83,236	2,876	23,411	210,558	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	574,101	798,097	40,915	248,755	1,661,868	30.00
31.00	03100	INTENSIVE CARE UNIT	33,373	112,808	2,873	9,085	158,139	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	509,621	423,692	115,026	121,471	1,169,810	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	28,966	5,967	30,582	57,883	123,398	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	377,451	204,796	84,192	57,778	724,217	54.00
56.00	05600	RADIOISOTOPE	121,143	11,935	0	0	133,078	56.00
56.01	03630	ULTRA SOUND	74,544	10,344	15,097	22,472	122,457	56.01
57.00	05700	CT SCAN	157,040	16,709	0	27,808	201,557	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	268,500	34,214	0	0	302,714	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	681,146	87,346	23,848	82,441	874,781	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	22,976	7,957	0	852	31,785	62.00
65.00	06500	RESPIRATORY THERAPY	84,147	24,666	0	20,243	129,056	65.00
66.00	06600	PHYSICAL THERAPY	350,742	148,878	13,302	99,493	612,415	66.00
67.00	06700	OCCUPATIONAL THERAPY	99,009	13,526	496	28,608	141,639	67.00
68.00	06800	SPEECH PATHOLOGY	50,157	4,774	719	14,323	69,973	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	97,558	73,555	51,150	24,231	246,494	69.01
69.02	03650	VASCULAR LAB	37,490	4,774	0	11,302	53,566	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,463	0	0	0	13,463	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-12,707	0	0	0	-12,707	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	719,719	414,807	1,973	171,439	1,307,938	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	757,657	312,211	42,232	122,243	1,234,343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,429,324	4,105,506	567,603	1,532,946	15,263,026	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,880	40,446	190	1,005	52,521	190.00
190.01	19001	FOUNDATION	22,216	0	2,558	6,651	31,425	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	16,745	0	15	0	16,760	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,596	115,018	415	0	121,029	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	15,484,761	4,260,970	570,781	1,540,602	15,484,761	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/26/2015 9:48 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,737,364					5.00
7.00	00700	OPERATION OF PLANT	313,323	1,299,234				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,356	7,413	116,703			8.00
9.00	00900	HOUSEKEEPING	62,898	14,253	15,266	290,335		9.00
10.00	01000	DIETARY	52,982	39,678	0	7,280	266,654	10.00
11.00	01100	CAFETERIA	45,600	13,536	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	4,046	5,157	0	2,355	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	15,499	0	0	4,710	0	14.00
15.00	01500	PHARMACY	119,701	24,369	0	5,995	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	66,915	33,715	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	528,145	323,276	31,348	121,830	257,131	30.00
31.00	03100	INTENSIVE CARE UNIT	50,257	45,694	815	1,713	9,523	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	371,766	171,621	10,562	33,187	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	39,216	2,417	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	230,156	82,955	7,675	27,834	0	54.00
56.00	05600	RADIOISOTOPE	42,292	4,834	0	0	0	56.00
56.01	03630	ULTRA SOUND	38,917	4,190	0	0	0	56.01
57.00	05700	CT SCAN	64,055	6,768	0	3,640	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	96,203	13,859	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	278,005	35,381	0	13,917	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	10,101	3,223	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	41,014	9,991	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	194,625	60,305	7,179	11,776	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,013	5,479	0	1,927	0	67.00
68.00	06800	SPEECH PATHOLOGY	22,237	1,934	0	1,713	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	78,336	29,794	4,911	5,353	0	69.01
69.02	03650	VASCULAR LAB	17,023	1,934	0	2,998	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,279	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	415,663	168,022	0	11,348	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	392,274	126,464	38,947	27,620	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,666,897	1,236,262	116,703	285,196	266,654	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	16,691	16,383	0	0	0	190.00
190.01	19001	FOUNDATION	9,987	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	5,326	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	38,463	46,589	0	5,139	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,737,364	1,299,234	116,703	290,335	266,654	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet B Part I Date/Time Prepared: 2/26/2015 9:48 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	202,622					11.00
13.00	01300	NURSING ADMINISTRATION	0	24,289				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,693	0	70,672			14.00
15.00	01500	PHARMACY	4,178	923	0	531,822		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,340	0	0	0	319,528	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,189	7,998	996	0	17,149	30.00
31.00	03100	INTENSIVE CARE UNIT	1,345	297	872	0	1,053	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,749	3,259	57,098	0	36,192	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,165	0	0	0	8,418	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,473	2,535	0	0	20,738	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	4,496	56.00
56.01	03630	ULTRA SOUND	4,004	885	0	0	7,840	56.01
57.00	05700	CT SCAN	5,254	1,161	0	0	38,396	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	14,038	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	20,319	0	0	0	70,192	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	206	0	0	0	726	62.00
65.00	06500	RESPIRATORY THERAPY	4,447	983	0	0	8,777	65.00
66.00	06600	PHYSICAL THERAPY	18,452	0	0	0	10,740	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,004	0	0	0	2,004	67.00
68.00	06800	SPEECH PATHOLOGY	2,374	0	0	0	555	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	5,333	1,178	996	0	10,506	69.01
69.02	03650	VASCULAR LAB	2,817	0	0	0	2,088	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	237	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	531,822	11,153	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	29,371	0	4,483	0	12,632	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	22,946	5,070	6,227	0	41,598	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	200,659	24,289	70,672	531,822	319,528	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	396	0	0	0	0	190.00
190.01	19001	FOUNDATION	1,567	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	202,622	24,289	70,672	531,822	319,528	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/26/2015 9:48 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,985,930	0	2,985,930		30.00
31.00	03100	INTENSIVE CARE UNIT	0	269,708	0	269,708		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,868,244	0	1,868,244		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	176,614	0	176,614		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,107,583	0	1,107,583		54.00
56.00	05600	RADIOISOTOPE	0	184,700	0	184,700		56.00
56.01	03630	ULTRA SOUND	0	178,293	0	178,293		56.01
57.00	05700	CT SCAN	0	320,831	0	320,831		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	426,814	0	426,814		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	1,292,595	0	1,292,595		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	46,041	0	46,041		62.00
65.00	06500	RESPIRATORY THERAPY	0	194,268	0	194,268		65.00
66.00	06600	PHYSICAL THERAPY	0	915,492	0	915,492		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	200,066	0	200,066		67.00
68.00	06800	SPEECH PATHOLOGY	0	98,786	0	98,786		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	382,901	0	382,901		69.01
69.02	03650	VASCULAR LAB	0	80,426	0	80,426		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	17,979	0	17,979		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	530,268	0	530,268		73.00
73.01	03480	ONCOLOGY	0	0	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,949,457	0	1,949,457		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
91.00	09100	EMERGENCY	0	1,895,489	0	1,895,489		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	15,122,485	0	15,122,485		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	85,991	0	85,991		190.00
190.01	19001	FOUNDATION	0	42,979	0	42,979		190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	22,086	0	22,086		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	211,220	0	211,220		192.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	15,484,761	0	15,484,761		202.00

COST ALLOCATION STATISTICS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet Non-CMS W | Date/Time Prepared: 2/26/2015 9:48 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	9	TIME SPENT	9.00
10.00	DIETARY	10	PATIENT DAYS	10.00
11.00	CAFETERIA	11	FTE'S	11.00
13.00	NURSING ADMINISTRATION	13	NURSING FTE'S	13.00
14.00	CENTRAL SERVICES & SUPPLY	14	COSTED REQUIS.	14.00
15.00	PHARMACY	15	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	C	GROSS CHARGES	16.00
17.00	SOCIAL SERVICE	17	TIME SPENT	17.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet B Part II Date/Time Prepared: 2/26/2015 9:48 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	19,229	644	19,873	19,873	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	674,858	105,585	780,443	3,067	5.00
7.00	00700	OPERATION OF PLANT	0	359,376	17,928	377,304	578	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,300	0	18,300	0	8.00
9.00	00900	HOUSEKEEPING	0	35,186	603	35,789	435	9.00
10.00	01000	DIETARY	0	97,955	6,891	104,846	124	10.00
11.00	01100	CAFETERIA	0	33,418	0	33,418	358	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,731	0	12,731	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	7,253	7,253	104	14.00
15.00	01500	PHARMACY	0	60,161	3,418	63,579	353	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	83,236	2,876	86,112	302	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	798,097	40,915	839,012	3,206	30.00
31.00	03100	INTENSIVE CARE UNIT	0	112,808	2,873	115,681	117	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	423,692	115,026	538,718	1,567	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	5,967	30,582	36,549	747	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	204,796	84,192	288,988	745	54.00
56.00	05600	RADIOISOTOPE	0	11,935	0	11,935	0	56.00
56.01	03630	ULTRA SOUND	0	10,344	15,097	25,441	290	56.01
57.00	05700	CT SCAN	0	16,709	0	16,709	359	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	34,214	0	34,214	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	87,346	23,848	111,194	1,064	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	7,957	0	7,957	11	62.00
65.00	06500	RESPIRATORY THERAPY	0	24,666	0	24,666	261	65.00
66.00	06600	PHYSICAL THERAPY	0	148,878	13,302	162,180	1,284	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	13,526	496	14,022	369	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,774	719	5,493	185	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	73,555	51,150	124,705	313	69.01
69.02	03650	VASCULAR LAB	0	4,774	0	4,774	146	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	414,807	1,973	416,780	2,212	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	312,211	42,232	354,443	1,577	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,105,506	567,603	4,673,109	19,774	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	40,446	190	40,636	13	190.00
190.01	19001	FOUNDATION	0	0	2,558	2,558	86	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	15	15	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	115,018	415	115,433	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	4,260,970	570,781	4,831,751	19,873	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/26/2015 9:48 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	783,510					5.00
7.00	00700	OPERATION OF PLANT	65,685	443,567				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,525	2,531	26,356			8.00
9.00	00900	HOUSEKEEPING	13,186	4,866	3,448	57,724		9.00
10.00	01000	DIETARY	11,107	13,546	0	1,447	131,070	10.00
11.00	01100	CAFETERIA	9,560	4,621	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	848	1,761	0	468	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,249	0	0	937	0	14.00
15.00	01500	PHARMACY	25,094	8,320	0	1,192	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	14,028	11,511	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	110,726	110,370	7,079	24,222	126,389	30.00
31.00	03100	INTENSIVE CARE UNIT	10,536	15,600	184	341	4,681	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	77,937	58,593	2,385	6,598	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	8,221	825	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,250	28,321	1,733	5,534	0	54.00
56.00	05600	RADIOISOTOPE	8,866	1,650	0	0	0	56.00
56.01	03630	ULTRA SOUND	8,159	1,430	0	0	0	56.01
57.00	05700	CT SCAN	13,429	2,311	0	724	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20,168	4,731	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	58,281	12,079	0	2,767	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,118	1,100	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	8,598	3,411	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	40,802	20,588	1,621	2,341	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,437	1,871	0	383	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,662	660	0	341	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	16,422	10,172	1,109	1,064	0	69.01
69.02	03650	VASCULAR LAB	3,569	660	0	596	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	897	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	87,140	57,364	0	2,256	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	82,237	43,176	8,797	5,491	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	768,737	422,068	26,356	56,702	131,070	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,499	5,593	0	0	0	190.00
190.01	19001	FOUNDATION	2,094	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	1,117	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,063	15,906	0	1,022	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	783,510	443,567	26,356	57,724	131,070	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet B Part II Date/Time Prepared: 2/26/2015 9:48 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	47,957					11.00
13.00	01300	NURSING ADMINISTRATION	0	15,808				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	401	0	11,944			14.00
15.00	01500	PHARMACY	989	601	0	100,128		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,974	0	0	0	113,927	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,565	5,204	168	0	6,113	30.00
31.00	03100	INTENSIVE CARE UNIT	318	193	147	0	376	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,491	2,121	9,651	0	12,902	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	749	0	0	0	3,001	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,715	1,650	0	0	7,393	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	1,603	56.00
56.01	03630	ULTRA SOUND	948	576	0	0	2,795	56.01
57.00	05700	CT SCAN	1,243	756	0	0	13,688	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	5,004	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,809	0	0	0	25,042	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	49	0	0	0	259	62.00
65.00	06500	RESPIRATORY THERAPY	1,052	640	0	0	3,129	65.00
66.00	06600	PHYSICAL THERAPY	4,367	0	0	0	3,829	66.00
67.00	06700	OCCUPATIONAL THERAPY	948	0	0	0	714	67.00
68.00	06800	SPEECH PATHOLOGY	562	0	0	0	198	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	1,262	767	168	0	3,745	69.01
69.02	03650	VASCULAR LAB	667	0	0	0	744	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	84	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	100,128	3,976	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,952	0	758	0	4,503	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	5,431	3,300	1,052	0	14,829	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,492	15,808	11,944	100,128	113,927	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	94	0	0	0	0	190.00
190.01	19001	FOUNDATION	371	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	47,957	15,808	11,944	100,128	113,927	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/26/2015 9:48 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	0					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,241,054	0	1,241,054		30.00
31.00	03100	INTENSIVE CARE UNIT	0	148,174	0	148,174		31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0		41.00
42.00	04200	SUBPROVIDER	0	0	0	0		42.00
43.00	04300	NURSERY	0	0	0	0		43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	713,963	0	713,963		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	50,092	0	50,092		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	385,329	0	385,329		54.00
56.00	05600	RADIOISOTOPE	0	24,054	0	24,054		56.00
56.01	03630	ULTRA SOUND	0	39,639	0	39,639		56.01
57.00	05700	CT SCAN	0	49,219	0	49,219		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	64,117	0	64,117		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00	06000	LABORATORY	0	215,236	0	215,236		60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	11,494	0	11,494		62.00
65.00	06500	RESPIRATORY THERAPY	0	41,757	0	41,757		65.00
66.00	06600	PHYSICAL THERAPY	0	237,012	0	237,012		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	27,744	0	27,744		67.00
68.00	06800	SPEECH PATHOLOGY	0	12,101	0	12,101		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
69.01	03160	CARDIOPULMONARY	0	159,727	0	159,727		69.01
69.02	03650	VASCULAR LAB	0	11,156	0	11,156		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	981	0	981		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	104,104	0	104,104		73.00
73.01	03480	ONCOLOGY	0	0	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	577,965	0	577,965		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
91.00	09100	EMERGENCY	0	520,333	0	520,333		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,635,251	0	4,635,251		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	49,835	0	49,835		190.00
190.01	19001	FOUNDATION	0	5,109	0	5,109		190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	1,132	0	1,132		190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	140,424	0	140,424		192.00
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	4,831,751	0	4,831,751		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/26/2015 9:48 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	96,394					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		580,247				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	435	655	5,110,465			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,267	107,336	788,591	-3,737,364	11,760,104	5.00
7.00	00700	OPERATION OF PLANT	8,130	18,225	148,599	0	985,911	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	0	0	0	82,934	8.00
9.00	00900	HOUSEKEEPING	796	613	111,844	0	197,918	9.00
10.00	01000	DIETARY	2,216	7,005	32,004	0	166,714	10.00
11.00	01100	CAFETERIA	756	0	92,146	0	143,486	11.00
13.00	01300	NURSING ADMINISTRATION	288	0	0	0	12,731	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,373	26,663	0	48,770	14.00
15.00	01500	PHARMACY	1,361	3,475	90,896	0	376,656	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,883	2,924	77,660	0	210,558	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,055	41,594	825,162	0	1,661,868	30.00
31.00	03100	INTENSIVE CARE UNIT	2,552	2,921	30,137	0	158,139	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,585	116,934	402,942	0	1,169,810	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	135	31,089	192,009	0	123,398	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,633	85,588	191,662	0	724,217	54.00
56.00	05600	RADIOISOTOPE	270	0	0	0	133,078	56.00
56.01	03630	ULTRA SOUND	234	15,347	74,544	0	122,457	56.01
57.00	05700	CT SCAN	378	0	92,246	0	201,557	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	774	0	0	0	302,714	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,976	24,244	273,472	0	874,781	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	2,827	0	31,785	62.00
65.00	06500	RESPIRATORY THERAPY	558	0	67,150	0	129,056	65.00
66.00	06600	PHYSICAL THERAPY	3,368	13,523	330,038	0	612,415	66.00
67.00	06700	OCCUPATIONAL THERAPY	306	504	94,897	0	141,639	67.00
68.00	06800	SPEECH PATHOLOGY	108	731	47,511	0	69,973	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	1,664	51,998	80,380	0	246,494	69.01
69.02	03650	VASCULAR LAB	108	0	37,490	0	53,566	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	13,463	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,707	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,384	2,006	568,695	0	1,307,938	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	7,063	42,932	405,504	0	1,234,343	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	92,877	577,017	5,085,069	-3,724,657	11,538,369	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	915	193	3,334	0	52,521	190.00
190.01	19001	FOUNDATION	0	2,600	22,062	0	31,425	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	15	0	0	16,760	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,602	422	0	0	121,029	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,260,970	570,781	1,540,602		3,737,364	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	44.203685	0.983686	0.301460		0.317800	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			19,873		783,510	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.003889		0.066624	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/26/2015 9:48 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	72,562					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	414	12,453				8.00
9.00	00900	HOUSEKEEPING	796	1,629	1,356			9.00
10.00	01000	DIETARY	2,216	0	34	756		10.00
11.00	01100	CAFETERIA	756	0	0	0	12,804	11.00
13.00	01300	NURSING ADMINISTRATION	288	0	11	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	22	0	107	14.00
15.00	01500	PHARMACY	1,361	0	28	0	264	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,883	0	0	0	527	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	18,055	3,345	569	729	2,287	30.00
31.00	03100	INTENSIVE CARE UNIT	2,552	87	8	27	85	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,585	1,127	155	0	932	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	135	0	0	0	200	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,633	819	130	0	725	54.00
56.00	05600	RADIOISOTOPE	270	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	234	0	0	0	253	56.01
57.00	05700	CT SCAN	378	0	17	0	332	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	774	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,976	0	65	0	1,284	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	0	0	13	62.00
65.00	06500	RESPIRATORY THERAPY	558	0	0	0	281	65.00
66.00	06600	PHYSICAL THERAPY	3,368	766	55	0	1,166	66.00
67.00	06700	OCCUPATIONAL THERAPY	306	0	9	0	253	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	8	0	150	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	1,664	524	25	0	337	69.01
69.02	03650	VASCULAR LAB	108	0	14	0	178	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,384	0	53	0	1,856	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	7,063	4,156	129	0	1,450	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,045	12,453	1,332	756	12,680	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	915	0	0	0	25	190.00
190.01	19001	FOUNDATION	0	0	0	0	99	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,602	0	24	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,299,234	116,703	290,335	266,654	202,622	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	17.905157	9.371477	214.111357	352.716931	15.824898	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	443,567	26,356	57,724	131,070	47,957	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.112938	2.116438	42.569322	173.373016	3.745470	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/26/2015 9:48 am

		Cost Center Description	NURSING ADMINISTRATION (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	6,946					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,135				14.00
15.00	01500	PHARMACY	264	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	29,719,323		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,287	16	0	1,594,957	0	30.00
31.00	03100	INTENSIVE CARE UNIT	85	14	0	97,971	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	932	917	0	3,366,083	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	782,968	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	725	0	0	1,928,749	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	418,120	0	56.00
56.01	03630	ULTRA SOUND	253	0	0	729,186	0	56.01
57.00	05700	CT SCAN	332	0	0	3,571,059	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	1,305,620	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	6,529,581	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	67,491	0	62.00
65.00	06500	RESPIRATORY THERAPY	281	0	0	816,295	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	998,884	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	186,407	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	51,653	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	337	16	0	977,117	0	69.01
69.02	03650	VASCULAR LAB	0	0	0	194,234	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,011	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	1,037,273	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	72	0	1,174,821	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	1,450	100	0	3,868,843	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,946	1,135	100	29,719,323	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	FOUNDATION	0	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	24,289	70,672	531,822	319,528	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.496833	62.266079	5,318.220000	0.010752	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	15,808	11,944	100,128	113,927	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.275842	10.523348	1,001.280000	0.003833	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/26/2015 9:48 am

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	2,985,930		2,985,930	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	269,708		269,708	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,868,244		1,868,244	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	176,614		176,614	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,107,583		1,107,583	0	0	54.00
56.00	05600	RADIOISOTOPE	184,700		184,700	0	0	56.00
56.01	03630	ULTRA SOUND	178,293		178,293	0	0	56.01
57.00	05700	CT SCAN	320,831		320,831	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	426,814		426,814	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,292,595		1,292,595	0	0	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	46,041		46,041	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	194,268	0	194,268	0	0	65.00
66.00	06600	PHYSICAL THERAPY	915,492	0	915,492	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	200,066	0	200,066	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	98,786	0	98,786	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	382,901		382,901	0	0	69.01
69.02	03650	VASCULAR LAB	80,426		80,426	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,979		17,979	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	530,268		530,268	0	0	73.00
73.01	03480	ONCOLOGY	0		0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,949,457		1,949,457	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	1,895,489		1,895,489	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	804,727		804,727		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	15,927,212	0	15,927,212	0	0	200.00
201.00		Less Observation Beds	804,727		804,727		0	201.00
202.00		Total (see instructions)	15,122,485	0	15,122,485	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,293,679		1,293,679			30.00
31.00	03100	INTENSIVE CARE UNIT	97,971		97,971			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	317,401	3,048,682	3,366,083	0.555020	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	65,984	716,984	782,968	0.225570	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,064	1,887,685	1,928,749	0.574249	0.000000	54.00
56.00	05600	RADIOISOTOPE	25,780	392,340	418,120	0.441739	0.000000	56.00
56.01	03630	ULTRA SOUND	8,408	720,778	729,186	0.244510	0.000000	56.01
57.00	05700	CT SCAN	73,543	3,497,516	3,571,059	0.089842	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,663	1,286,957	1,305,620	0.326905	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	317,938	6,211,643	6,529,581	0.197960	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	9,772	57,719	67,491	0.682180	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	386,241	430,054	816,295	0.237987	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	128,199	870,685	998,884	0.916515	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	66,931	119,476	186,407	1.073275	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,702	47,951	51,653	1.912493	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	93,244	883,873	977,117	0.391868	0.000000	69.01
69.02	03650	VASCULAR LAB	14,768	179,466	194,234	0.414068	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,011	22,011	0.816819	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	291,391	745,882	1,037,273	0.511214	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,174,821	1,174,821			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00	09100	EMERGENCY	82,052	3,786,791	3,868,843	0.489937	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	301,278	301,278	2.671045	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,336,731	26,382,592	29,719,323			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,336,731	26,382,592	29,719,323			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
56.01	03630	ULTRA SOUND	0.000000		56.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
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
69.02	03650	VASCULAR LAB	0.000000		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	03480	ONCOLOGY	0.000000		73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		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: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/26/2015 9:48 am

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	2,985,930		2,985,930	0	2,985,930	30.00
31.00	03100	INTENSIVE CARE UNIT	269,708		269,708	0	269,708	31.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		0	0	0	43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,868,244		1,868,244	0	1,868,244	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	176,614		176,614	0	176,614	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,107,583		1,107,583	0	1,107,583	54.00
56.00	05600	RADIOISOTOPE	184,700		184,700	0	184,700	56.00
56.01	03630	ULTRA SOUND	178,293		178,293	0	178,293	56.01
57.00	05700	CT SCAN	320,831		320,831	0	320,831	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	426,814		426,814	0	426,814	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	1,292,595		1,292,595	0	1,292,595	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	46,041		46,041	0	46,041	62.00
65.00	06500	RESPIRATORY THERAPY	194,268	0	194,268	0	194,268	65.00
66.00	06600	PHYSICAL THERAPY	915,492	0	915,492	0	915,492	66.00
67.00	06700	OCCUPATIONAL THERAPY	200,066	0	200,066	0	200,066	67.00
68.00	06800	SPEECH PATHOLOGY	98,786	0	98,786	0	98,786	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	382,901		382,901	0	382,901	69.01
69.02	03650	VASCULAR LAB	80,426		80,426	0	80,426	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,979		17,979	0	17,979	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	530,268		530,268	0	530,268	73.00
73.01	03480	ONCOLOGY	0		0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,949,457		1,949,457	0	1,949,457	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100	EMERGENCY	1,895,489		1,895,489	0	1,895,489	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	804,727		804,727		804,727	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	15,927,212	0	15,927,212	0	15,927,212	200.00
201.00		Less Observation Beds	804,727		804,727		804,727	201.00
202.00		Total (see instructions)	15,122,485	0	15,122,485	0	15,122,485	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/26/2015 9:48 am

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	1,293,679		1,293,679			30.00
31.00	03100	INTENSIVE CARE UNIT	97,971		97,971			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	0		0			43.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	317,401	3,048,682	3,366,083	0.555020	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	65,984	716,984	782,968	0.225570	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,064	1,887,685	1,928,749	0.574249	0.000000	54.00
56.00	05600	RADIOISOTOPE	25,780	392,340	418,120	0.441739	0.000000	56.00
56.01	03630	ULTRA SOUND	8,408	720,778	729,186	0.244510	0.000000	56.01
57.00	05700	CT SCAN	73,543	3,497,516	3,571,059	0.089842	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	18,663	1,286,957	1,305,620	0.326905	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	317,938	6,211,643	6,529,581	0.197960	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	9,772	57,719	67,491	0.682180	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	386,241	430,054	816,295	0.237987	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	128,199	870,685	998,884	0.916515	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	66,931	119,476	186,407	1.073275	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	3,702	47,951	51,653	1.912493	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	93,244	883,873	977,117	0.391868	0.000000	69.01
69.02	03650	VASCULAR LAB	14,768	179,466	194,234	0.414068	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,011	22,011	0.816819	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	291,391	745,882	1,037,273	0.511214	0.000000	73.00
73.01	03480	ONCOLOGY	0	0	0	0.000000	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,174,821	1,174,821	1.659365	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
91.00	09100	EMERGENCY	82,052	3,786,791	3,868,843	0.489937	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	301,278	301,278	2.671045	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,336,731	26,382,592	29,719,323			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,336,731	26,382,592	29,719,323			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/26/2015 9:48 am

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
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
56.01	03630	ULTRA SOUND	0.000000		56.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000		62.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
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
69.02	03650	VASCULAR LAB	0.000000		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	03480	ONCOLOGY	0.000000		73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		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: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D Part II Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	713,963	3,366,083	0.212105	101,324	21,491	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	50,092	782,968	0.063977	21,087	1,349	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	385,329	1,928,749	0.199782	22,848	4,565	54.00
56.00	05600	RADIOISOTOPE	24,054	418,120	0.057529	18,018	1,037	56.00
56.01	03630	ULTRA SOUND	39,639	729,186	0.054361	4,960	270	56.01
57.00	05700	CT SCAN	49,219	3,571,059	0.013783	32,654	450	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	64,117	1,305,620	0.049108	2,606	128	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	215,236	6,529,581	0.032963	182,892	6,029	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	11,494	67,491	0.170304	6,282	1,070	62.00
65.00	06500	RESPIRATORY THERAPY	41,757	816,295	0.051154	289,428	14,805	65.00
66.00	06600	PHYSICAL THERAPY	237,012	998,884	0.237277	40,816	9,685	66.00
67.00	06700	OCCUPATIONAL THERAPY	27,744	186,407	0.148836	14,518	2,161	67.00
68.00	06800	SPEECH PATHOLOGY	12,101	51,653	0.234275	2,334	547	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	159,727	977,117	0.163468	12,719	2,079	69.01
69.02	03650	VASCULAR LAB	11,156	194,234	0.057436	14,194	815	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	981	22,011	0.044569	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	104,104	1,037,273	0.100363	144,959	14,549	73.00
73.01	03480	ONCOLOGY	0	0	0.000000	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	577,965	1,174,821	0.491960	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100	EMERGENCY	520,333	3,868,843	0.134493	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	390,045	301,278	1.294635	0	0	92.00
200.00		Total (lines 50-199)	3,636,068	28,327,673		911,639	81,030	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D Part IV Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
69.02	03650	VASCULAR LAB	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,366,083	0.000000	0.000000	101,324	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	782,968	0.000000	0.000000	21,087	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,928,749	0.000000	0.000000	22,848	54.00
56.00	05600	RADIOISOTOPE	0	418,120	0.000000	0.000000	18,018	56.00
56.01	03630	ULTRA SOUND	0	729,186	0.000000	0.000000	4,960	56.01
57.00	05700	CT SCAN	0	3,571,059	0.000000	0.000000	32,654	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,305,620	0.000000	0.000000	2,606	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	6,529,581	0.000000	0.000000	182,892	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	67,491	0.000000	0.000000	6,282	62.00
65.00	06500	RESPIRATORY THERAPY	0	816,295	0.000000	0.000000	289,428	65.00
66.00	06600	PHYSICAL THERAPY	0	998,884	0.000000	0.000000	40,816	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	186,407	0.000000	0.000000	14,518	67.00
68.00	06800	SPEECH PATHOLOGY	0	51,653	0.000000	0.000000	2,334	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	03160	CARDIOPULMONARY	0	977,117	0.000000	0.000000	12,719	69.01
69.02	03650	VASCULAR LAB	0	194,234	0.000000	0.000000	14,194	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,011	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,037,273	0.000000	0.000000	144,959	73.00
73.01	03480	ONCOLOGY	0	0	0.000000	0.000000	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,174,821	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	3,868,843	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	301,278	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	28,327,673			911,639	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D Part IV Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
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
69.02	03650	VASCULAR LAB	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D Part IV Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
			23.00	24.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	03630	ULTRA SOUND	0	0	56.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
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
69.02	03650	VASCULAR LAB	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	03480	ONCOLOGY	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.555020	0	1,294,941	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.225570	0	240,634	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.574249	0	520,892	0	0	54.00
56.00	05600	RADIOISOTOPE	0.441739	0	155,294	0	0	56.00
56.01	03630	ULTRA SOUND	0.244510	0	113,428	0	0	56.01
57.00	05700	CT SCAN	0.089842	0	1,375,578	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.326905	0	350,153	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.197960	0	2,281,879	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.682180	0	26,690	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.237987	0	280,012	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.916515	0	237,641	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.073275	0	23,565	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.912493	0	8,002	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.391868	0	248,394	0	0	69.01
69.02	03650	VASCULAR LAB	0.414068	0	169,636	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.816819	0	15,507	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.511214	0	238,681	2,506	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	0.489937	0	1,066,867	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.671045	0	149,884	0	0	92.00
200.00		Subtotal (see instructions)		0	8,797,678	2,506	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	8,797,678	2,506	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	718,718	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	54,280	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	299,122	0		54.00
56.00	05600	RADIOISOTOPE	68,599	0		56.00
56.01	03630	ULTRA SOUND	27,734	0		56.01
57.00	05700	CT SCAN	123,585	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	114,467	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	451,721	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	18,207	0		62.00
65.00	06500	RESPIRATORY THERAPY	66,639	0		65.00
66.00	06600	PHYSICAL THERAPY	217,802	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	25,292	0		67.00
68.00	06800	SPEECH PATHOLOGY	15,304	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	97,338	0		69.01
69.02	03650	VASCULAR LAB	70,241	0		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,666	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	122,017	1,281		73.00
73.01	03480	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	522,698	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	400,347	0		92.00
200.00		Subtotal (see instructions)	3,426,777	1,281		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,426,777	1,281		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141325 | Component CCN: 14Z325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/26/2015 9:48 am

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	0.555020	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.225570	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.574249	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.441739	0	0	0	0	56.00
56.01	03630	ULTRA SOUND	0.244510	0	0	0	0	56.01
57.00	05700	CT SCAN	0.089842	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.326905	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.197960	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.682180	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.237987	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.916515	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.073275	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.912493	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.391868	0	0	0	0	69.01
69.02	03650	VASCULAR LAB	0.414068	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.816819	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.511214	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	0.489937	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.671045	0	0	0	0	92.00
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: 141325 | Component CCN: 14Z325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D Part V | Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	03630	ULTRA SOUND	0	0		56.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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
69.02	03650	VASCULAR LAB	0	0		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	03480	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/26/2015 9:48 am

Title XIX | 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	0.555020	0	810,830	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.225570	0	326,618	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.574249	0	599,864	0	0	54.00
56.00	05600	RADIOISOTOPE	0.441739	0	124,677	0	0	56.00
56.01	03630	ULTRA SOUND	0.244510	0	229,047	0	0	56.01
57.00	05700	CT SCAN	0.089842	0	1,111,433	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.326905	0	408,966	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.197960	0	1,710,062	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.682180	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.237987	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.916515	0	260,094	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.073275	0	46,755	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.912493	0	3,160	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.391868	0	374,070	0	0	69.01
69.02	03650	VASCULAR LAB	0.414068	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.816819	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.511214	0	249,764	0	0	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.659365				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00	09100	EMERGENCY	0.489937	0	2,544,697	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.671045	0	120,781	0	0	92.00
200.00		Subtotal (see instructions)		0	8,920,818	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	8,920,818	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/26/2015 9:48 am

Title XIX | 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	450,027	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	73,675	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	344,471	0		54.00
56.00	05600	RADIOISOTOPE	55,075	0		56.00
56.01	03630	ULTRA SOUND	56,004	0		56.01
57.00	05700	CT SCAN	99,853	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	133,693	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	338,524	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	238,380	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	50,181	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,043	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	146,586	0		69.01
69.02	03650	VASCULAR LAB	0	0		69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	127,683	0		73.00
73.01	03480	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00	09100	EMERGENCY	1,246,741	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	322,611	0		92.00
200.00		Subtotal (see instructions)	3,689,547	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,689,547	0		202.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141325	Period: From 04/01/2014 To 09/30/2014	Worksheet D-1 Date/Time Prepared: 2/26/2015 9:48 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	993	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	840	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	576	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	139	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	14	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	361	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	44	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	123.34	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	123.34	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,985,930	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,727	25.00
26.00	Total swing-bed cost (see instructions)	425,430	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,560,500	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,560,500	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)	3,048.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,100,407	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,100,407	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	269,708	27	9,989.19	12	119,870	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)	338,862	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,559,139	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)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	134,122	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	134,122	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)	264	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,048.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	804,727	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,241,054	2,560,500	0.484692	804,727	390,045	90.00
91.00	Nursing School cost	0	2,560,500	0.000000	804,727	0	91.00
92.00	Allied health cost	0	2,560,500	0.000000	804,727	0	92.00
93.00	All other Medical Education	0	2,560,500	0.000000	804,727	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141325	Period: From 04/01/2014 To 09/30/2014	Worksheet D-1 Date/Time Prepared: 2/26/2015 9:48 am
	Title XIX	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)	993	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	840	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	576	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	139	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	14	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	78	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	14	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	123.34	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	123.34	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,985,930	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,727	25.00
26.00	Total swing-bed cost (see instructions)	425,430	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,560,500	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,560,500	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)	3,048.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	237,761	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	237,761	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/26/2015 9:48 am

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	269,708	27	9,989.19	5	49,946	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)	116,796	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	404,503	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)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	1,727	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	1,727	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)	264	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	3,048.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	804,727	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/26/2015 9:48 am

Title XIX | 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	1,241,054	2,560,500	0.484692	804,727	390,045	90.00
91.00	Nursing School cost	0	2,560,500	0.000000	804,727	0	91.00
92.00	Allied health cost	0	2,560,500	0.000000	804,727	0	92.00
93.00	All other Medical Education	0	2,560,500	0.000000	804,727	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		499,568		30.00
31.00	03100	INTENSIVE CARE UNIT		37,960		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.555020	101,324	56,237	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.225570	21,087	4,757	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.574249	22,848	13,120	54.00
56.00	05600	RADIOISOTOPE	0.441739	18,018	7,959	56.00
56.01	03630	ULTRA SOUND	0.244510	4,960	1,213	56.01
57.00	05700	CT SCAN	0.089842	32,654	2,934	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.326905	2,606	852	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.197960	182,892	36,205	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.682180	6,282	4,285	62.00
65.00	06500	RESPIRATORY THERAPY	0.237987	289,428	68,880	65.00
66.00	06600	PHYSICAL THERAPY	0.916515	40,816	37,408	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.073275	14,518	15,582	67.00
68.00	06800	SPEECH PATHOLOGY	1.912493	2,334	4,464	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.391868	12,719	4,984	69.01
69.02	03650	VASCULAR LAB	0.414068	14,194	5,877	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.816819	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.511214	144,959	74,105	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.489937	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.671045	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		911,639	338,862	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)		911,639		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141325 | Component CCN: 14Z325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.555020	40	22	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.225570	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.574249	734	421	54.00
56.00	05600	RADIOISOTOPE	0.441739	0	0	56.00
56.01	03630	ULTRA SOUND	0.244510	0	0	56.01
57.00	05700	CT SCAN	0.089842	1,845	166	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.326905	2,696	881	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.197960	8,054	1,594	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.682180	698	476	62.00
65.00	06500	RESPIRATORY THERAPY	0.237987	660	157	65.00
66.00	06600	PHYSICAL THERAPY	0.916515	18,542	16,994	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.073275	12,875	13,818	67.00
68.00	06800	SPEECH PATHOLOGY	1.912493	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.391868	0	0	69.01
69.02	03650	VASCULAR LAB	0.414068	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.816819	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.511214	14,114	7,215	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
91.00	09100	EMERGENCY	0.489937	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.671045	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		60,258	41,744	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)		60,258		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/26/2015 9:48 am

Title XIX | 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		132,928		30.00
31.00	03100	INTENSIVE CARE UNIT		20,858		31.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.555020	39,849	22,117	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.225570	12,746	2,875	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.574249	5,609	3,221	54.00
56.00	05600	RADIOISOTOPE	0.441739	3,521	1,555	56.00
56.01	03630	ULTRA SOUND	0.244510	1,148	281	56.01
57.00	05700	CT SCAN	0.089842	10,046	903	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.326905	2,549	833	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.197960	48,922	9,685	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.682180	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.237987	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.916515	1,708	1,565	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.073275	690	741	67.00
68.00	06800	SPEECH PATHOLOGY	1.912493	342	654	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.391868	55,553	21,769	69.01
69.02	03650	VASCULAR LAB	0.414068	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.816819	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.511214	37,002	18,916	73.00
73.01	03480	ONCOLOGY	0.000000	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.659365	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	09100	EMERGENCY	0.489937	64,663	31,681	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	2.671045	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		284,348	116,796	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)		284,348		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141325	Period: From 04/01/2014 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 2/26/2015 9:48 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,428,058	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,428,058	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,462,339	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)	5,422	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,295,881	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,161,036	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,161,036	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,161,036	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)	193,001	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	146,681	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	177,707	36.00
37.00	Subtotal (see instructions)	2,307,717	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,307,717	40.00
40.01	Sequestration adjustment (see instructions)	46,154	40.01
41.00	Interim payments	2,021,985	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	239,578	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

		Overrides 1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		780,254		1,915,645	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	09/30/2014	34,984	09/30/2014	239,109	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	05/27/2014	41,345	05/27/2014	132,769	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)		-6,361		106,340	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)		773,893		2,021,985	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		661,109		239,578	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,435,002		2,261,563	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: 141325 | Component CCN: 14Z325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2015 9:48 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		94,770		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	05/27/2014	15,197		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)		-15,197		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)		79,573		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		94,499		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		174,072		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: 141325	Period: From 04/01/2014 To 09/30/2014	Worksheet E-1 Part II Date/Time Prepared: 2/26/2015 9:48 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	0	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	0	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	0	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	0	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	0	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141325 Component CCN: 14Z325	Period: From 04/01/2014 To 09/30/2014	Worksheet E-2 Date/Time Prepared: 2/26/2015 9:48 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	135,463	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)	42,161	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	44	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)	177,624	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	177,624	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)	177,624	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	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)	177,624	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)	177,624	0	19.00
19.01	Sequestration adjustment (see instructions)	3,552	0	19.01
20.00	Interim payments	79,573	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	94,499	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: 141325	Period: From 04/01/2014 To 09/30/2014	Worksheet E-3 Part V Date/Time Prepared: 2/26/2015 9:48 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,559,139	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)	1,559,139	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,574,730	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)	1,574,730	19.00
20.00	Deductibles (exclude professional component)	128,896	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,445,834	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,445,834	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	24,282	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	18,454	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	23,098	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,464,288	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)	1,464,288	30.00
30.01	Sequestration adjustment (see instructions)	29,286	30.01
31.00	Interim payments	773,893	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	661,109	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	127,216	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet E-3 Part VII Date/Time Prepared: 2/26/2015 9:48 am

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	404,503		1.00
2.00	Medical and other services		3,689,547	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	404,503	3,689,547	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	404,503	3,689,547	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	274,566		8.00
9.00	Ancillary service charges	284,348	8,920,818	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	558,914	8,920,818	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	558,914	8,920,818	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	154,411	5,231,271	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	404,503	3,689,547	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	404,503	3,689,547	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	404,503	3,689,547	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	404,503	3,689,547	36.00
37.00	ADJUSTMENT	-404,503	-3,689,547	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
	OVERRIDES			
109.00	Override Ancillary service charges (line 9)	0	0	109.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet G | Date/Time Prepared: 2/26/2015 9:48 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	3,513,377	0	0	0	1.00
2.00	Temporary investments	24,962,630	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,533,092	0	0	0	4.00
5.00	Other receivable	241,944	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	401,756	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	448,083	0	0	0	9.00
10.00	Due from other funds	-1,180,286	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	34,920,596	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	588,318	0	0	0	12.00
13.00	Land improvements	854,467	0	0	0	13.00
14.00	Accumulated depreciation	598,220	0	0	0	14.00
15.00	Buildings	20,224,022	0	0	0	15.00
16.00	Accumulated depreciation	-16,697,859	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	24,499,722	0	0	0	23.00
24.00	Accumulated depreciation	-14,819,759	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	5,781	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	15,252,912	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	757,532	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	757,532	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	50,931,040	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	575,527	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,225,953	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	600,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,127,336	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,528,816	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	23,435,432	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	23,435,432	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	27,964,248	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	22,966,792				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)	22,966,792	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	50,931,040	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet G-1 | Date/Time Prepared: 2/26/2015 9:48 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		22,613,031		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		353,761				2.00
3.00	Total (sum of line 1 and line 2)		22,966,792		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		22,966,792		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)		22,966,792		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141325 | Period: From 04/01/2014 To 09/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/26/2015 9:48 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,152,766		1,152,766	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	128,019		128,019	5.00
6.00	Swing bed - NF	12,894		12,894	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)	1,293,679		1,293,679	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	97,971		97,971	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)	97,971		97,971	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,391,650		1,391,650	17.00
18.00	Ancillary services	1,863,029	21,119,702	22,982,731	18.00
19.00	Outpatient services	82,052	4,088,069	4,170,121	19.00
20.00	RURAL HEALTH CLINIC	0	1,174,821	1,174,821	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL REVENUES	81,360	3,201,212	3,282,572	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,418,091	29,583,804	33,001,895	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,388,537		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		14,388,537		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141325	Period: From 04/01/2014 To 09/30/2014	Worksheet G-3 Date/Time Prepared: 2/26/2015 9:48 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	33,001,895	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,039,889	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,962,006	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,388,537	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-426,531	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	190,047	6.00
7.00	Income from investments	425,278	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	68,061	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	2,677	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	0	23.00
24.00	OTHER REVENUE	94,229	24.00
25.00	Total other income (sum of lines 6-24)	780,292	25.00
26.00	Total (line 5 plus line 25)	353,761	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	353,761	29.00

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

Provider CCN: 141325 Component CCN: 143445 | Period: From 04/01/2014 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/26/2015 9:48 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	277,375	0	277,375	-147,809	129,566	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	199,762	0	199,762	0	199,762	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	137,940	0	137,940	0	137,940	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)	615,077	0	615,077	-147,809	467,268	10.00
11.00	Physician Services Under Agreement	0	170,071	170,071	-13,117	156,954	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	170,071	170,071	-13,117	156,954	14.00
15.00	Medical Supplies	0	5,837	5,837	0	5,837	15.00
16.00	Transportation (Health Care Staff)	0	6,596	6,596	0	6,596	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	24,572	24,572	0	24,572	18.00
19.00	Other Health Care Costs	0	5,912	5,912	0	5,912	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	42,917	42,917	0	42,917	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	615,077	212,988	828,065	-160,926	667,139	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	101,427	7,442	108,869	0	108,869	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	101,427	7,442	108,869	0	108,869	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	716,504	220,430	936,934	-160,926	776,008	32.00

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

Provider CCN: 141325 | Component CCN: 143445 | Period: From 04/01/2014 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/26/2015 9:48 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	129,566		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	199,762		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	137,940		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	467,268		10.00
11.00	Physician Services Under Agreement	-54,038	102,916		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	-54,038	102,916		14.00
15.00	Medical Supplies	0	5,837		15.00
16.00	Transportation (Health Care Staff)	0	6,596		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	24,572		18.00
19.00	Other Health Care Costs	0	5,912		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	42,917		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-54,038	613,101		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-2,251	106,618		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-2,251	106,618		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-56,289	719,719		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141325 | Component CCN: 143445 | Period: From 04/01/2014 To 09/30/2014 | Worksheet M-2 | Date/Time Prepared: 2/26/2015 9:48 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.21	938	4,200	882		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.00	4,853	2,100	4,200		3.00
4.00	Subtotal (sum of lines 1-3)	2.21	5,791		5,082	5,791	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.21	5,791			5,791	8.00
9.00	Physician Services Under Agreements		324			324	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)					613,101	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)					613,101	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)					106,618	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,229,738	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,336,356	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					1,336,356	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,336,356	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,949,457	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141325 Component CCN: 143445	Period: From 04/01/2014 To 09/30/2014	Worksheet M-3 Date/Time Prepared: 2/26/2015 9:48 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,949,457	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		13,040	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,936,417	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,791	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		324	5.00
6.00	Total adjusted visits (line 4 plus line 5)		6,115	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		316.67	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)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	316.67	316.67	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	828	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	262,203	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) *		262,203	16.00
16.01	Total program charges (see instructions)(from contractor's records)		108,716	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,132	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		14,789	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.)		194,790	16.04
16.05	Total program cost (see instructions)		209,579	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		3,927	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		19,731	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		209,579	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		80	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		209,659	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		209,659	26.00
26.01	Sequestration adjustment (see instructions)		4,193	26.01
27.00	Interim payments		128,897	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		76,569	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: 141325 Component CCN: 143445	Period: From 04/01/2014 To 09/30/2014	Worksheet M-4 Date/Time Prepared: 2/26/2015 9:48 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	467,268	467,268	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000434	0.000091	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	203	43	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,595	260	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	3,798	303	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	613,101	613,101	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	1,336,356	1,336,356	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006195	0.000494	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	8,279	660	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	12,077	963	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	57	12	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	211.88	80.25	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	1	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	80	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)		13,040	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)		80	16.00

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

Provider CCN: 141325 Component CCN: 143445 | Period: From 04/01/2014 To 09/30/2014 | Worksheet M-5 | Date/Time Prepared: 2/26/2015 9:48 am

Rural Health Clinic (RHC) I | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		130,822	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		05/27/2014	1,925	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)		-1,925	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		128,897	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		76,569	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		205,466	7.00

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