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: 141327	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/18/2015 10:19 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/18/2015 Time: 10:19 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WABASH GENERAL HOSPITAL (141327) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 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	206,481	-460,359	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	54,873	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		813		0	10.00
200.00	Total	0	261,354	-459,546	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: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2015 10:17 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1418 COLLEGE DRIVE	PO Box:			1.00
2.00	City: MT. CARMEL	State: IL	Zip Code: 62863-	County: WABASH	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	WABASH GENERAL HOSPITAL	141327	14999	1	06/01/2003	N	O	N	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	WABASH GENERAL HOSPITAL SWING BEDS	14Z327	14999		06/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	WABASH GENERAL RHC	148501	14999		04/01/2009	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)	01/01/2014	12/31/2014	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period 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) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2015 10:17 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)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		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 Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. 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 Wkst. D, Parts III & IV and D-2, Pt. 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, § 2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. 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: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2015 10:17 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 Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider 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 nonprovider 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: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2015 10:17 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 nonprovider 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. (see 42 CFR 412.424(d)(1)(iii)(c)) 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, 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (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, 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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (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
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2015 10:17 am

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		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 Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

		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 column 1 is 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 hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2015 10:17 am

		1.00	2.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

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

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the 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, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141327	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/18/2015 10:17 am

		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)	01/01/2014	12/31/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 5/18/2015 10:17 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	05/15/2013	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	04/15/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/18/2015 10:17 am

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RICH	FERRIELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923832	RFERRIELL@ALLIANTMANAGEMENT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 5/18/2015 10:17 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)	04/15/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 5/18/2015 10:17 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	21	7,665	54,919.00	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)		21	7,665	54,919.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	2,062.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	56,981.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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						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: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/18/2015 10:17 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)	1,618	122	2,291			1.00
2.00	HMO and other (see instructions)	80	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	374	0	374			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		84	84			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,992	206	2,749			7.00
8.00	INTENSIVE CARE UNIT	45	41	86			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)	2,037	247	2,835	0.00	219.28	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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	292	0	4,840	0.00	1.88	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	221.16	27.00
28.00	Observation Bed Days		0	313			28.00
29.00	Ambulance Trips	781					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: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 5/18/2015 10:17 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	453	44	657	1.00
2.00	HMO and other (see instructions)			19	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	453	44	657	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						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						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 WAGE RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 5/18/2015 10:17 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	326,879	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	2,644,295	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	201,071	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	897,170	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	12,723	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	4,082,138	24.00
	Part B - Other than Core Related Cost		
25.00	EMPLOYEE BENEFITS	-9,566	25.00

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

Provider CCN: 141327 Component CCN: 148501 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 | Date/Time Prepared: 5/18/2015 10:17 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1418 COLLEGE DRIVE	1.00
	City	State	Zip Code
	1.00	2.00	3.00
2.00	City, State, Zip Code, County	MT.CARMEL IL	62863 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
9.01		0	9.01
9.02		0	9.02
9.03		0	9.03
9.04		0	9.04
9.05		0	9.05
9.06		0	9.06
9.07		0	9.07
9.08		0	9.08
9.09		0	9.09
9.10		0	9.10
		1.00	2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0 10.00

		Sunday		Monday		Tuesday
		from	to	from	to	from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	Clinic	12:00	21:00	18:00	21:00	18:00 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

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

Provider CCN: 141327
Component CCN: 148501

Period: From 01/01/2014 To 12/31/2014

Worksheet S-8
Date/Time Prepared: 5/18/2015 10:17 am

Rural Health Clinic (RHC) I

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		WABASH				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	21:00	18:00	21:00	18:00	21:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	18:00	21:00	12:00	21:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 5/18/2015 10:17 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)	0.409718	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,211,697	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	68,844	5.00
6.00	Medicaid charges	12,361,380	6.00
7.00	Medicaid cost (line 1 times line 6)	5,064,680	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)	2,784,139	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)	2,784,139	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	52,677	11,629	64,306	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	21,583	4,765	26,348	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)	21,583	4,765	26,348	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)	4,366,287	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	352,431	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	4,013,856	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,644,549	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,670,897	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,455,036	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/18/2015 10:17 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		611,582	611,582	0	611,582	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		692,693	692,693	751,765	1,444,458	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	125,347	4,507,094	4,632,441	0	4,632,441	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,053,102	3,084,317	4,137,419	116,347	4,253,766	5.00
7.00	00700	OPERATION OF PLANT	176,063	831,187	1,007,250	32,531	1,039,781	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	214,135	46,676	260,811	123,247	384,058	9.00
10.00	01000	DIETARY	337,258	230,635	567,893	-392,702	175,191	10.00
11.00	01100	CAFETERIA	0	0	0	391,590	391,590	11.00
13.00	01300	NURSING ADMINISTRATION	212,747	17,137	229,884	0	229,884	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	356,690	65,444	422,134	0	422,134	16.00
17.00	01700	SOCIAL SERVICE	137,557	8,162	145,719	0	145,719	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	695,906	52,185	748,091	-6,491	741,600	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,259,424	341,330	1,600,754	-54,316	1,546,438	30.00
31.00	03100	INTENSIVE CARE UNIT	241,560	3,146	244,706	-1,833	242,873	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	670,084	303,703	973,787	-81,532	892,255	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	631,851	932,054	1,563,905	-139,664	1,424,241	54.00
60.00	06000	LABORATORY	683,349	639,312	1,322,661	-73,655	1,249,006	60.00
65.00	06500	RESPIRATORY THERAPY	465,638	161,579	627,217	-31,590	595,627	65.00
66.00	06600	PHYSICAL THERAPY	671,085	53,470	724,555	-2,081	722,474	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	109,657	2,684,603	2,794,260	-1,708,066	1,086,194	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,885,318	1,885,318	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	361,047	1,552,204	1,913,251	5,199	1,918,450	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	164,220	42,537	206,757	-1,541	205,216	88.00
90.00	09000	CLINIC	147,701	133,574	281,275	-314	280,961	90.00
90.01	09001	ORTHOPAEDIC CLINIC	2,529,472	369,323	2,898,795	-63,985	2,834,810	90.01
90.02	09002	SURGICAL CLINIC	673,931	163,057	836,988	-41,698	795,290	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	834,775	1,728,583	2,563,358	-188,924	2,374,434	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	553,113	111,253	664,366	-17,418	646,948	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		317,241	317,241	-317,241	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,305,712	19,684,081	32,989,793	182,946	33,172,739	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	455,294	667,250	1,122,544	-182,946	939,598	192.00
200.00		TOTAL (SUM OF LINES 118-199)	13,761,006	20,351,331	34,112,337	0	34,112,337	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 5/18/2015 10:17 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	611,582		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-301,858	1,142,600		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,077,773	3,554,668		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-187,963	4,065,803		5.00
7.00	00700	OPERATION OF PLANT	0	1,039,781		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	384,058		9.00
10.00	01000	DIETARY	-4,915	170,276		10.00
11.00	01100	CAFETERIA	-80,751	310,839		11.00
13.00	01300	NURSING ADMINISTRATION	0	229,884		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-19,147	402,987		16.00
17.00	01700	SOCIAL SERVICE	0	145,719		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-695,906	45,694		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-243,000	1,303,438		30.00
31.00	03100	INTENSIVE CARE UNIT	0	242,873		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	892,255		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-2,574	1,421,667		54.00
60.00	06000	LABORATORY	-45,999	1,203,007		60.00
65.00	06500	RESPIRATORY THERAPY	-62,242	533,385		65.00
66.00	06600	PHYSICAL THERAPY	0	722,474		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,190	1,085,004		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,885,318		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-4,142	1,914,308		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	205,216		88.00
90.00	09000	CLINIC	-111,200	169,761		90.00
90.01	09001	ORTHOPAEDIC CLINIC	-1,729,485	1,105,325		90.01
90.02	09002	SURGICAL CLINIC	-570,336	224,954		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	-886,364	1,488,070		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	646,948		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,024,845	27,147,894		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	939,598		192.00
200.00		TOTAL (SUM OF LINES 118-199)	-6,024,845	28,087,492		200.00

RECLASSIFICATIONS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/18/2015 10:17 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RENT				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	356,012	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	TOTALS		0	356,012	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	232,556	159,034	1.00
	TOTALS		232,556	159,034	
	C - IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,832	1.00
	TOTALS		0	6,832	
	D - MATERIALS MANAGEMENT				
1.00	ADMINISTRATIVE & GENERAL	5.00	54,412	0	1.00
	TOTALS		54,412	0	
	E - INTEREST				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	317,241	1.00
	TOTALS		0	317,241	
	F - OXYGEN				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	10,748	1.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	10,748	
	G - MED SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	227,748	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	227,748	
	H - UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	32,531	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	32,531	
	I - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,885,318	1.00
	TOTALS		0	1,885,318	
	J - LINEN				
1.00	HOUSEKEEPING	9.00	0	123,247	1.00
	TOTALS		0	123,247	
	L - INSURANCE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	78,512	1.00
	TOTALS		0	78,512	
	M - MALPRACTICE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	142,895	1.00
	TOTALS		0	142,895	
500.00	Grand Total: Increases		286,968	3,340,118	500.00

RECLASSIFICATIONS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 5/18/2015 10:17 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,448	9		1.00
2.00	DIETARY	10.00	0	1,112	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,868	0		3.00
4.00	OPERATING ROOM	50.00	0	34,442	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	131,031	0		5.00
6.00	LABORATORY	60.00	0	43,343	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	7,583	0		7.00
9.00	ORTHOPAEDIC CLINIC	90.01	0	53,319	0		9.00
10.00	SURGICAL CLINIC	90.02	0	33,132	0		10.00
11.00	AMBULANCE SERVICES	95.00	0	11,000	0		11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	35,734	0		12.00
	TOTALS		0	356,012			
	B - CAFETERIA						
1.00	DIETARY	10.00	232,556	159,034	0		1.00
	TOTALS		232,556	159,034			
	C - IV SOLUTIONS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,832	0		1.00
	TOTALS		0	6,832			
	D - MATERIALS MANAGEMENT						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	54,412	0	0		1.00
	TOTALS		54,412	0			
	E - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	317,241	9		1.00
	TOTALS		0	317,241			
	F - OXYGEN						
1.00		0.00	0	0	0		1.00
3.00	RESPIRATORY THERAPY	65.00	0	9,946	0		3.00
4.00	AMBULANCE SERVICES	95.00	0	802	0		4.00
	TOTALS		0	10,748			
	G - MED SUPPLIES						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	6,491	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	51,448	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	1,833	0		3.00
4.00	OPERATING ROOM	50.00	0	47,090	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,633	0		5.00
6.00	LABORATORY	60.00	0	30,312	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	14,061	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	2,081	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,633	0		9.00
10.00	CLINIC	90.00	0	314	0		10.00
11.00	ORTHOPAEDIC CLINIC	90.01	0	10,666	0		11.00
12.00	EMERGENCY	91.00	0	46,029	0		12.00
13.00	RURAL HEALTH CLINIC	88.00	0	1,541	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	5,616	0		14.00
	TOTALS		0	227,748			
	H - UTILITIES						
1.00	SURGICAL CLINIC	90.02	0	8,566	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	23,965	0		2.00
	TOTALS		0	32,531			
	I - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	1,885,318	0		1.00
	TOTALS		0	1,885,318			
	J - LINEN						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	123,247	0		1.00
	TOTALS		0	123,247			
	L - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	78,512	9		1.00
	TOTALS		0	78,512			
	M - MALPRACTICE						
1.00	EMERGENCY	91.00	0	142,895	0		1.00
	TOTALS		0	142,895			
500.00	Grand Total: Decreases		286,968	3,340,118			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 5/18/2015 10:17 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	416,867	0	0	0	0	1.00
2.00	Land Improvements	1,483,762	70,054	0	70,054	0	2.00
3.00	Buildings and Fixtures	16,411,974	2,496,347	0	2,496,347	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,639,500	8,975	0	8,975	0	5.00
6.00	Movable Equipment	10,728,775	475,120	0	475,120	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	32,680,878	3,050,496	0	3,050,496	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	32,680,878	3,050,496	0	3,050,496	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	416,867	0	1.00
2.00	Land Improvements	1,553,816	0	2.00
3.00	Buildings and Fixtures	18,908,321	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	3,648,475	0	5.00
6.00	Movable Equipment	11,203,895	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,731,374	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	35,731,374	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 5/18/2015 10:17 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	611,582	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	692,693	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,304,275	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	611,582		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	692,693		2.00
3.00	Total (sum of lines 1-2)	0	1,304,275		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 5/18/2015 10:17 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1	0	1	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1	0	1	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	611,582	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,142,600	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,754,182	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	611,582	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,142,600	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,754,182	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/18/2015 10:17 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-125,225	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
3.00	Investment income - other (chapter 2)	B	-20,821	ADMINISTRATIVE & GENERAL	5.00	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	-3,651,692			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	492			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-80,751	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	B	-1,190	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-4,142	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-19,147	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-176,633	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 5/18/2015 10:17 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	
33.00	DIETARY	B	-4,915	DIETARY	10.00	0	33.00
35.00	MISCELLANEOUS	B	-22,708	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	PHYSICIAN RECRUITMENT	A	-144,434	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	PUBLIC RELATIONS	A	-297,946	EMPLOYEE BENEFITS	4.00	0	37.00
39.00	CRNA SALARY	A	-695,906	NONPHYSICIAN ANESTHETISTS	19.00	0	39.00
40.00	CRNA EMP BEN	A	-205,954	EMPLOYEE BENEFITS	4.00	0	40.00
42.00	EMPLOYEE DISCOUNT	A	106,759	EMPLOYEE BENEFITS	4.00	0	42.00
43.00	ORTHO EMP BEN	A	-511,841	EMPLOYEE BENEFITS	4.00	0	43.00
44.00	SURGEONS EMP BEN	A	-168,791	EMPLOYEE BENEFITS	4.00	0	44.00
45.00			0		0.00	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,024,845				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: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 5/18/2015 10:17 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	54.00	RADIOLOGY-DIAGNOSTIC	DSS MRI	210,530	210,038	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	210,530	210,038	5.00

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

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

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

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

6.00	A	DSS MRI	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141327	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 5/18/2015 10:17 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	492	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	492			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			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: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 5/18/2015 10:17 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	243,000	243,000	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	3,066	3,066	0	0	0	2.00
3.00	60.00	LABORATORY	45,999	45,999	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	62,242	62,242	0	0	0	4.00
5.00	90.00	CLINIC	111,200	111,200	0	0	0	5.00
6.00	90.01	ORTHOPAEDIC CLINIC	1,729,485	1,729,485	0	0	0	6.00
7.00	90.02	SURGICAL CLINIC	570,336	570,336	0	0	0	7.00
8.00	91.00	EMERGENCY	1,481,927	886,364	595,563	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			4,247,255	3,651,692	595,563		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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	0	0	6.00
7.00	90.02	SURGICAL CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	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	243,000		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	3,066		2.00
3.00	60.00	LABORATORY	0	0	0	45,999		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	62,242		4.00
5.00	90.00	CLINIC	0	0	0	111,200		5.00
6.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	1,729,485		6.00
7.00	90.02	SURGICAL CLINIC	0	0	0	570,336		7.00
8.00	91.00	EMERGENCY	0	0	0	886,364		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	3,651,692		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/18/2015 10:17 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	611,582	611,582				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,142,600		1,142,600			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,554,668	1,333	2,490	3,558,491		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,065,803	40,251	75,200	370,837	4,552,091	5.00
7.00	00700	OPERATION OF PLANT	1,039,781	23,879	44,612	58,884	1,167,156	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	384,058	5,979	11,170	71,617	472,824	9.00
10.00	01000	DIETARY	170,276	37,984	70,964	35,017	314,241	10.00
11.00	01100	CAFETERIA	310,839	0	0	77,778	388,617	11.00
13.00	01300	NURSING ADMINISTRATION	229,884	2,869	5,360	71,153	309,266	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	402,987	10,792	20,162	119,294	553,235	16.00
17.00	01700	SOCIAL SERVICE	145,719	3,563	6,657	46,006	201,945	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	45,694	0	0	0	45,694	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,303,438	93,432	174,559	421,207	1,992,636	30.00
31.00	03100	INTENSIVE CARE UNIT	242,873	23,416	43,747	80,789	390,825	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	892,255	64,584	120,660	224,108	1,301,607	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,421,667	45,240	84,520	211,321	1,762,748	54.00
60.00	06000	LABORATORY	1,203,007	9,329	17,430	228,544	1,458,310	60.00
65.00	06500	RESPIRATORY THERAPY	533,385	10,273	19,193	155,731	718,582	65.00
66.00	06600	PHYSICAL THERAPY	722,474	63,973	119,518	224,442	1,130,407	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,085,004	12,273	22,928	18,044	1,138,249	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,885,318	0	0	0	1,885,318	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,914,308	4,683	8,749	120,751	2,048,491	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	205,216	9,274	17,326	54,923	286,739	88.00
90.00	09000	CLINIC	169,761	12,356	23,084	49,398	254,599	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,105,325	66,638	124,498	267,553	1,564,014	90.01
90.02	09002	SURGICAL CLINIC	224,954	0	0	34,647	259,601	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	1,488,070	30,385	56,768	279,188	1,854,411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	646,948	33,023	61,696	184,987	926,654	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,147,894	605,529	1,131,291	3,406,219	26,978,260	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,369	4,427	0	6,796	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	939,598	3,684	6,882	152,272	1,102,436	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)	28,087,492	611,582	1,142,600	3,558,491	28,087,492	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/18/2015 10:17 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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,552,091					5.00
7.00	00700	OPERATION OF PLANT	225,745	1,392,901				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	91,451	15,250	0	579,525		9.00
10.00	01000	DIETARY	60,779	96,879	0	10,208	482,107	10.00
11.00	01100	CAFETERIA	75,164	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	59,817	7,318	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	107,004	27,525	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	39,059	9,088	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	8,838	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	385,406	238,303	0	247,969	467,482	30.00
31.00	03100	INTENSIVE CARE UNIT	75,591	59,723	0	0	14,625	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	251,750	164,723	0	87,807	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	340,942	115,387	0	48,154	0	54.00
60.00	06000	LABORATORY	282,059	23,795	0	2,575	0	60.00
65.00	06500	RESPIRATORY THERAPY	138,985	26,203	0	7,633	0	65.00
66.00	06600	PHYSICAL THERAPY	218,638	163,165	0	71,983	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	220,154	31,302	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	364,649	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	396,200	11,945	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	55,460	23,653	0	0	0	88.00
90.00	09000	CLINIC	49,243	31,514	0	962	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	302,504	169,964	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	50,211	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	358,671	77,499	0	102,234	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	179,229	84,227	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,337,549	1,377,463	0	579,525	482,107	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,314	6,043	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	213,228	9,395	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)	4,552,091	1,392,901	0	579,525	482,107	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 5/18/2015 10:17 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	463,781					11.00
13.00	01300	NURSING ADMINISTRATION	5,880	382,281				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,960	0	713,724			16.00
17.00	01700	SOCIAL SERVICE	6,225	0	0	256,317		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	7,315	0	0	0	61,847	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	70,709	175,185	85,830	248,542	0	30.00
31.00	03100	INTENSIVE CARE UNIT	11,101	27,504	0	7,775	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,898	79,029	76,538	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	61,847	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,402	0	199,376	0	0	54.00
60.00	06000	LABORATORY	33,476	0	69,451	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	23,063	0	24,095	0	0	65.00
66.00	06600	PHYSICAL THERAPY	27,624	0	18,426	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,270	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,040	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,393	0	28,032	0	0	88.00
90.00	09000	CLINIC	8,462	0	64,412	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	70,594	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	14,830	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	40,589	100,563	137,485	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	37,950	0	10,079	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	463,781	382,281	713,724	256,317	61,847	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	463,781	382,281	713,724	256,317	61,847	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 5/18/2015 10:17 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,912,062	0	3,912,062		30.00
31.00	03100	INTENSIVE CARE UNIT	587,144	0	587,144		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,993,352	0	1,993,352		50.00
53.00	05300	ANESTHESIOLOGY	61,847	0	61,847		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,496,009	0	2,496,009		54.00
60.00	06000	LABORATORY	1,869,666	0	1,869,666		60.00
65.00	06500	RESPIRATORY THERAPY	938,561	0	938,561		65.00
66.00	06600	PHYSICAL THERAPY	1,630,243	0	1,630,243		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,392,975	0	1,392,975		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,249,967	0	2,249,967		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,466,676	0	2,466,676		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	399,277	0	399,277		88.00
90.00	09000	CLINIC	409,192	0	409,192		90.00
90.01	09001	ORTHOPAEDIC CLINIC	2,107,076	0	2,107,076		90.01
90.02	09002	SURGICAL CLINIC	324,642	0	324,642		90.02
90.03	09003	OP CLINIC	0	0	0		90.03
91.00	09100	EMERGENCY	2,671,452	0	2,671,452		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,238,139	0	1,238,139		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,748,280	0	26,748,280		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,153	0	14,153		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,325,059	0	1,325,059		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	28,087,492	0	28,087,492		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/18/2015 10:17 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,333	2,490	3,823	3,823	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	40,251	75,200	115,451	398	5.00
7.00	00700	OPERATION OF PLANT	0	23,879	44,612	68,491	63	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	5,979	11,170	17,149	77	9.00
10.00	01000	DIETARY	0	37,984	70,964	108,948	38	10.00
11.00	01100	CAFETERIA	0	0	0	0	83	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,869	5,360	8,229	76	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	10,792	20,162	30,954	128	16.00
17.00	01700	SOCIAL SERVICE	0	3,563	6,657	10,220	49	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	93,432	174,559	267,991	456	30.00
31.00	03100	INTENSIVE CARE UNIT	0	23,416	43,747	67,163	87	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	64,584	120,660	185,244	241	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	45,240	84,520	129,760	227	54.00
60.00	06000	LABORATORY	0	9,329	17,430	26,759	245	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,273	19,193	29,466	167	65.00
66.00	06600	PHYSICAL THERAPY	0	63,973	119,518	183,491	241	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,273	22,928	35,201	19	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,683	8,749	13,432	130	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	9,274	17,326	26,600	59	88.00
90.00	09000	CLINIC	0	12,356	23,084	35,440	53	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	66,638	124,498	191,136	287	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	37	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	30,385	56,768	87,153	300	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	33,023	61,696	94,719	199	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	605,529	1,131,291	1,736,820	3,660	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,369	4,427	6,796	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,684	6,882	10,566	163	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	611,582	1,142,600	1,754,182	3,823	202.00

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		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	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	115,849					5.00
7.00	00700	OPERATION OF PLANT	5,745	74,299				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	2,327	813	0	20,366		9.00
10.00	01000	DIETARY	1,547	5,168	0	359	116,060	10.00
11.00	01100	CAFETERIA	1,913	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,522	390	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,723	1,468	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	994	485	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	225	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,808	12,711	0	8,713	112,539	30.00
31.00	03100	INTENSIVE CARE UNIT	1,924	3,186	0	0	3,521	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,407	8,787	0	3,086	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,676	6,155	0	1,692	0	54.00
60.00	06000	LABORATORY	7,178	1,269	0	91	0	60.00
65.00	06500	RESPIRATORY THERAPY	3,537	1,398	0	268	0	65.00
66.00	06600	PHYSICAL THERAPY	5,564	8,703	0	2,530	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,602	1,670	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,280	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,090	637	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,411	1,262	0	0	0	88.00
90.00	09000	CLINIC	1,253	1,681	0	34	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,698	9,066	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	1,278	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	9,127	4,134	0	3,593	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	4,561	4,493	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	110,390	73,476	0	20,366	116,060	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33	322	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,426	501	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)	115,849	74,299	0	20,366	116,060	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 5/18/2015 10:17 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	1,996					11.00
13.00	01300	NURSING ADMINISTRATION	25	10,242				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	112	0	35,385			16.00
17.00	01700	SOCIAL SERVICE	27	0	0	11,775		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	31	0	0	0	256	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	305	4,694	4,255	11,418		30.00
31.00	03100	INTENSIVE CARE UNIT	48	737	0	357		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	137	2,117	3,795	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	127	0	9,884	0		54.00
60.00	06000	LABORATORY	144	0	3,443	0		60.00
65.00	06500	RESPIRATORY THERAPY	99	0	1,195	0		65.00
66.00	06600	PHYSICAL THERAPY	119	0	914	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	14	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	23	0	1,390	0		88.00
90.00	09000	CLINIC	36	0	3,193	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	304	0	0	0		90.01
90.02	09002	SURGICAL CLINIC	64	0	0	0		90.02
90.03	09003	OP CLINIC	0	0	0	0		90.03
91.00	09100	EMERGENCY	175	2,694	6,816	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	163	0	500	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,996	10,242	35,385	11,775	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments					256	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,996	10,242	35,385	11,775	256	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 5/18/2015 10:17 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	432,890	0	432,890		30.00
31.00	03100	INTENSIVE CARE UNIT	77,023	0	77,023		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	209,814	0	209,814		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,521	0	156,521		54.00
60.00	06000	LABORATORY	39,129	0	39,129		60.00
65.00	06500	RESPIRATORY THERAPY	36,130	0	36,130		65.00
66.00	06600	PHYSICAL THERAPY	201,562	0	201,562		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,506	0	42,506		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,280	0	9,280		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,332	0	24,332		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	30,745	0	30,745		88.00
90.00	09000	CLINIC	41,690	0	41,690		90.00
90.01	09001	ORTHOPAEDIC CLINIC	208,491	0	208,491		90.01
90.02	09002	SURGICAL CLINIC	1,379	0	1,379		90.02
90.03	09003	OP CLINIC	0	0	0		90.03
91.00	09100	EMERGENCY	113,992	0	113,992		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	104,635	0	104,635		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,730,119	0	1,730,119		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,151	0	7,151		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,656	0	16,656		192.00
200.00		Cross Foot Adjustments	256	0	256		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,754,182	0	1,754,182		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/18/2015 10:17 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	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	NEW CAP REL COSTS-BLDG & FIXT	66,079					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		66,079				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	144	144	10,639,931			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,349	4,349	1,108,807	-4,552,091	23,535,401	5.00
7.00	00700	OPERATION OF PLANT	2,580	2,580	176,063	0	1,167,156	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	646	646	214,135	0	472,824	9.00
10.00	01000	DIETARY	4,104	4,104	104,702	0	314,241	10.00
11.00	01100	CAFETERIA	0	0	232,556	0	388,617	11.00
13.00	01300	NURSING ADMINISTRATION	310	310	212,747	0	309,266	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,166	1,166	356,690	0	553,235	16.00
17.00	01700	SOCIAL SERVICE	385	385	137,557	0	201,945	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	45,694	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,095	10,095	1,259,424	0	1,992,636	30.00
31.00	03100	INTENSIVE CARE UNIT	2,530	2,530	241,560	0	390,825	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,978	6,978	670,084	0	1,301,607	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,888	4,888	631,851	0	1,762,748	54.00
60.00	06000	LABORATORY	1,008	1,008	683,349	0	1,458,310	60.00
65.00	06500	RESPIRATORY THERAPY	1,110	1,110	465,638	0	718,582	65.00
66.00	06600	PHYSICAL THERAPY	6,912	6,912	671,085	0	1,130,407	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,326	1,326	53,951	0	1,138,249	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,885,318	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	506	506	361,047	0	2,048,491	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,002	1,002	164,220	0	286,739	88.00
90.00	09000	CLINIC	1,335	1,335	147,701	0	254,599	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,200	7,200	799,987	0	1,564,014	90.01
90.02	09002	SURGICAL CLINIC	0	0	103,595	0	259,601	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	3,283	3,283	834,775	0	1,854,411	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,568	3,568	553,113	0	926,654	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	65,425	65,425	10,184,637	-4,552,091	22,426,169	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	256	256	0	0	6,796	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	398	398	455,294	0	1,102,436	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)	611,582	1,142,600	3,558,491		4,552,091	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.255316	17.291424	0.334447		0.193415	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			3,823		115,849	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000359		0.004922	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/18/2015 10:17 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (POUNDS)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	59,006					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,678				8.00
9.00	00900	HOUSEKEEPING	646	0	18,678			9.00
10.00	01000	DIETARY	4,104	329	329	8,505		10.00
11.00	01100	CAFETERIA	0	0	0	0	16,168	11.00
13.00	01300	NURSING ADMINISTRATION	310	0	0	0	205	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,166	0	0	0	905	16.00
17.00	01700	SOCIAL SERVICE	385	0	0	0	217	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	255	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,095	7,992	7,992	8,247	2,465	30.00
31.00	03100	INTENSIVE CARE UNIT	2,530	0	0	258	387	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,978	2,830	2,830	0	1,112	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,888	1,552	1,552	0	1,025	54.00
60.00	06000	LABORATORY	1,008	83	83	0	1,167	60.00
65.00	06500	RESPIRATORY THERAPY	1,110	246	246	0	804	65.00
66.00	06600	PHYSICAL THERAPY	6,912	2,320	2,320	0	963	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,326	0	0	0	114	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	506	0	0	0	350	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,002	0	0	0	188	88.00
90.00	09000	CLINIC	1,335	31	31	0	295	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,200	0	0	0	2,461	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	517	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	3,283	3,295	3,295	0	1,415	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,568	0	0	0	1,323	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,352	18,678	18,678	8,505	16,168	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	256	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	398	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)	1,392,901	0	579,525	482,107	463,781	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	23.606091	0.000000	31.027144	56.685126	28.685119	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	74,299	0	20,366	116,060	1,996	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.259177	0.000000	1.090374	13.646091	0.123454	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 5/18/2015 10:17 am

		Cost Center Description	NURSING ADMINISTRATION (NURSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	5,379					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	113,300				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,835			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,465	13,625	2,749			30.00
31.00	03100	INTENSIVE CARE UNIT	387	0	86			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,112	12,150	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,650	0	0		54.00
60.00	06000	LABORATORY	0	11,025	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,825	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	2,925	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	4,450	0	0		88.00
90.00	09000	CLINIC	0	10,225	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0		90.02
90.03	09003	OP CLINIC	0	0	0	0		90.03
91.00	09100	EMERGENCY	1,415	21,825	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,600	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,379	113,300	2,835	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	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)	382,281	713,724	256,317	61,847		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	71.069158	6.299417	90.411640	618.470000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,242	35,385	11,775	256		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.904071	0.312312	4.153439	2.560000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/18/2015 10:17 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	3,912,062		3,912,062	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	587,144		587,144	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,993,352		1,993,352	0	0	50.00
53.00	05300	ANESTHESIOLOGY	61,847		61,847	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,496,009		2,496,009	0	0	54.00
60.00	06000	LABORATORY	1,869,666		1,869,666	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	938,561	0	938,561	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,630,243	0	1,630,243	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,392,975		1,392,975	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,249,967		2,249,967	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,466,676		2,466,676	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	399,277		399,277	0	0	88.00
90.00	09000	CLINIC	409,192		409,192	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	2,107,076		2,107,076	0	0	90.01
90.02	09002	SURGICAL CLINIC	324,642		324,642	0	0	90.02
90.03	09003	OP CLINIC	0		0	0	0	90.03
91.00	09100	EMERGENCY	2,671,452		2,671,452	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	409,761		409,761		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,238,139		1,238,139	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	27,158,041	0	27,158,041	0	0	200.00
201.00		Less Observation Beds	409,761		409,761		0	201.00
202.00		Total (see instructions)	26,748,280	0	26,748,280	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/18/2015 10:17 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	3,083,983		3,083,983			30.00
31.00	03100	INTENSIVE CARE UNIT	121,955		121,955			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,290,576	6,371,514	10,662,090	0.186957	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	744,907	1,551,050	2,295,957	0.026937	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	714,569	11,128,680	11,843,249	0.210754	0.000000	54.00
60.00	06000	LABORATORY	1,029,736	8,689,841	9,719,577	0.192361	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	350,504	1,592,960	1,943,464	0.482932	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	632,651	2,780,796	3,413,447	0.477594	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,428,389	1,113,062	2,541,451	0.548102	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,563,364	601,361	4,164,725	0.540244	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,446,824	4,813,715	6,260,539	0.394004	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	454,972	454,972			88.00
90.00	09000	CLINIC	34	453,514	453,548	0.902202	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	716	1,197,182	1,197,898	1.758978	0.000000	90.01
90.02	09002	SURGICAL CLINIC	74	124,320	124,394	2.609788	0.000000	90.02
90.03	09003	OP CLINIC	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	62,952	4,968,499	5,031,451	0.530951	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	10,413	308,236	318,649	1.285932	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,653,236	1,653,236	0.748918	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,481,647	47,802,938	65,284,585			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,481,647	47,802,938	65,284,585			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/18/2015 10:17 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
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000		90.01
90.02	09002	SURGICAL CLINIC	0.000000		90.02
90.03	09003	OP CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/18/2015 10:17 am

Title XIX | Hospital

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,912,062		3,912,062	0	3,912,062	30.00
31.00	03100	INTENSIVE CARE UNIT	587,144		587,144	0	587,144	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,993,352		1,993,352	0	1,993,352	50.00
53.00	05300	ANESTHESIOLOGY	61,847		61,847	0	61,847	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,496,009		2,496,009	0	2,496,009	54.00
60.00	06000	LABORATORY	1,869,666		1,869,666	0	1,869,666	60.00
65.00	06500	RESPIRATORY THERAPY	938,561	0	938,561	0	938,561	65.00
66.00	06600	PHYSICAL THERAPY	1,630,243	0	1,630,243	0	1,630,243	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,392,975		1,392,975	0	1,392,975	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,249,967		2,249,967	0	2,249,967	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,466,676		2,466,676	0	2,466,676	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	399,277		399,277	0	399,277	88.00
90.00	09000	CLINIC	409,192		409,192	0	409,192	90.00
90.01	09001	ORTHOPAEDIC CLINIC	2,107,076		2,107,076	0	2,107,076	90.01
90.02	09002	SURGICAL CLINIC	324,642		324,642	0	324,642	90.02
90.03	09003	OP CLINIC	0		0	0	0	90.03
91.00	09100	EMERGENCY	2,671,452		2,671,452	0	2,671,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	409,761		409,761		409,761	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,238,139		1,238,139	0	1,238,139	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	27,158,041	0	27,158,041	0	27,158,041	200.00
201.00		Less Observation Beds	409,761		409,761		409,761	201.00
202.00		Total (see instructions)	26,748,280	0	26,748,280	0	26,748,280	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/18/2015 10:17 am

Title XIX | Hospital

		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	3,083,983		3,083,983			30.00
31.00	03100	INTENSIVE CARE UNIT	121,955		121,955			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,290,576	6,371,514	10,662,090	0.186957	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	744,907	1,551,050	2,295,957	0.026937	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	714,569	11,128,680	11,843,249	0.210754	0.000000	54.00
60.00	06000	LABORATORY	1,029,736	8,689,841	9,719,577	0.192361	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	350,504	1,592,960	1,943,464	0.482932	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	632,651	2,780,796	3,413,447	0.477594	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,428,389	1,113,062	2,541,451	0.548102	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,563,364	601,361	4,164,725	0.540244	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,446,824	4,813,715	6,260,539	0.394004	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	454,972	454,972	0.877586	0.000000	88.00
90.00	09000	CLINIC	34	453,514	453,548	0.902202	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	716	1,197,182	1,197,898	1.758978	0.000000	90.01
90.02	09002	SURGICAL CLINIC	74	124,320	124,394	2.609788	0.000000	90.02
90.03	09003	OP CLINIC	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	62,952	4,968,499	5,031,451	0.530951	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	10,413	308,236	318,649	1.285932	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,653,236	1,653,236	0.748918	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,481,647	47,802,938	65,284,585			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	17,481,647	47,802,938	65,284,585			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 5/18/2015 10:17 am

Title XIX | Hospital

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000		90.01
90.02	09002	SURGICAL CLINIC	0.000000		90.02
90.03	09003	OP CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 5/18/2015 10:17 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	209,814	10,662,090	0.019679	2,336,743	45,985	50.00
53.00	05300	ANESTHESIOLOGY	0	2,295,957	0.000000	404,736	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	156,521	11,843,249	0.013216	404,620	5,347	54.00
60.00	06000	LABORATORY	39,129	9,719,577	0.004026	741,263	2,984	60.00
65.00	06500	RESPIRATORY THERAPY	36,130	1,943,464	0.018591	282,131	5,245	65.00
66.00	06600	PHYSICAL THERAPY	201,562	3,413,447	0.059049	299,713	17,698	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,506	2,541,451	0.016725	798,236	13,350	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,280	4,164,725	0.002228	2,138,626	4,765	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,332	6,260,539	0.003887	806,502	3,135	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	30,745	454,972	0.067576	0	0	88.00
90.00	09000	CLINIC	41,690	453,548	0.091920	34	3	90.00
90.01	09001	ORTHOPAEDIC CLINIC	208,491	1,197,898	0.174047	716	125	90.01
90.02	09002	SURGICAL CLINIC	1,379	124,394	0.011086	74	1	90.02
90.03	09003	OP CLINIC	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	113,992	5,031,451	0.022656	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	52,033	318,649	0.163293	1,994	326	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,167,604	60,425,411		8,215,388	98,964	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/18/2015 10:17 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
53.00	05300	ANESTHESIOLOGY	61,847	0	0	0	61,847	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
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
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	61,847	0	0	0	61,847	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 5/18/2015 10:17 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	10,662,090	0.000000	0.000000	2,336,743	50.00
53.00	05300	ANESTHESIOLOGY	0	2,295,957	0.026937	0.000000	404,736	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,843,249	0.000000	0.000000	404,620	54.00
60.00	06000	LABORATORY	0	9,719,577	0.000000	0.000000	741,263	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,943,464	0.000000	0.000000	282,131	65.00
66.00	06600	PHYSICAL THERAPY	0	3,413,447	0.000000	0.000000	299,713	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,541,451	0.000000	0.000000	798,236	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	4,164,725	0.000000	0.000000	2,138,626	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,260,539	0.000000	0.000000	806,502	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	454,972	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	453,548	0.000000	0.000000	34	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	1,197,898	0.000000	0.000000	716	90.01
90.02	09002	SURGICAL CLINIC	0	124,394	0.000000	0.000000	74	90.02
90.03	09003	OP CLINIC	0	0	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	5,031,451	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	318,649	0.000000	0.000000	1,994	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	60,425,411			8,215,388	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV | Date/Time Prepared: 5/18/2015 10:17 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	10,902	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0	0		90.02
90.03	09003	OP CLINIC	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	10,902	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/18/2015 10:17 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	0.186957	0	1,428,163	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.026937	0	362,752	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210754	0	4,348,252	0	0	54.00
60.00	06000	LABORATORY	0.192361	0	4,243,334	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.482932	0	530,052	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.477594	0	966,575	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.548102	0	296,709	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.540244	0	118,447	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.394004	0	2,799,041	1,445	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.902202	0	19,020	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.758978	0	398,462	0	0	90.01
90.02	09002	SURGICAL CLINIC	2.609788	0	41,378	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.530951	0	1,638,596	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.285932	0	215,199	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.748918		0			95.00
200.00		Subtotal (see instructions)		0	17,405,980	1,445	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	17,405,980	1,445	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/18/2015 10:17 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	267,005	0	50.00
53.00	05300	ANESTHESIOLOGY	9,771	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	916,412	0	54.00
60.00	06000	LABORATORY	816,252	0	60.00
65.00	06500	RESPIRATORY THERAPY	255,979	0	65.00
66.00	06600	PHYSICAL THERAPY	461,630	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	162,627	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	63,990	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,102,833	569	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	17,160	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	700,886	0	90.01
90.02	09002	SURGICAL CLINIC	107,988	0	90.02
90.03	09003	OP CLINIC	0	0	90.03
91.00	09100	EMERGENCY	870,014	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	276,731	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	6,029,278	569	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	6,029,278	569	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141327 | Component CCN: 14Z327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/18/2015 10:17 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	0.186957	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.026937	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210754	0	0	0	0	54.00
60.00	06000	LABORATORY	0.192361	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.482932	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.477594	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.548102	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.540244	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.394004	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.902202	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.758978	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	2.609788	0	0	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.530951	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.285932	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.748918		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141327 | Component CCN: 14Z327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V | Date/Time Prepared: 5/18/2015 10:17 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/18/2015 10:17 am

Title XIX | Hospital

		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	0.186957	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.026937	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210754	0	0	0	0	54.00
60.00	06000	LABORATORY	0.192361	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.482932	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.477594	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.548102	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.540244	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.394004	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.877586				0	88.00
90.00	09000	CLINIC	0.902202	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.758978	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	2.609788	0	0	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.530951	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.285932	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.748918	0	0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 5/18/2015 10:17 am

Title XIX | Hospital

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/18/2015 10:17 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)	3,062	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,604	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)	2,291	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	374	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)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	84	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,618	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)	374	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	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	160.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	160.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,912,062	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)	13,440	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	503,058	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,409,004	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)	3,409,004	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,309.14	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,118,189	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)	2,118,189	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/18/2015 10:17 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)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	587,144	86	6,827.26	45	307,227	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)	2,869,735	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,295,151	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)	489,618	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)	489,618	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)	313	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,309.14	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	409,761	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/18/2015 10:17 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	432,890	3,409,004	0.126984	409,761	52,033	90.00
91.00	Nursing School cost	0	3,409,004	0.000000	409,761	0	91.00
92.00	Allied health cost	0	3,409,004	0.000000	409,761	0	92.00
93.00	All other Medical Education	0	3,409,004	0.000000	409,761	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141327	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/18/2015 10:17 am
	Title XIX	Hospital	

	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)	3,062	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,604	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)	2,291	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	374	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)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	84	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	122	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	84	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	90.06	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	90.06	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,912,062	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)	7,565	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	497,920	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,414,142	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)	3,414,142	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,311.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	159,955	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)	159,955	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/18/2015 10:17 am

Title XIX | Hospital

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	587,144	86	6,827.26	41	279,918	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	439,873	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)	439,873	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)	7,565	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)	7,565	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)	313	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,311.11	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	410,377	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 5/18/2015 10:17 am

Title XIX | Hospital

	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/18/2015 10:17 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		1,914,447		30.00
31.00	03100	INTENSIVE CARE UNIT		88,978		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.186957	2,336,743	436,870	50.00
53.00	05300	ANESTHESIOLOGY	0.026937	404,736	10,902	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210754	404,620	85,275	54.00
60.00	06000	LABORATORY	0.192361	741,263	142,590	60.00
65.00	06500	RESPIRATORY THERAPY	0.482932	282,131	136,250	65.00
66.00	06600	PHYSICAL THERAPY	0.477594	299,713	143,141	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.548102	798,236	437,515	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.540244	2,138,626	1,155,380	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.394004	806,502	317,765	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.902202	34	31	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.758978	716	1,259	90.01
90.02	09002	SURGICAL CLINIC	2.609788	74	193	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.530951	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.285932	1,994	2,564	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		8,215,388	2,869,735	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)		8,215,388		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141327 | Component CCN: 14Z327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/18/2015 10:17 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.186957	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.026937	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210754	28,428	5,991	54.00
60.00	06000	LABORATORY	0.192361	58,418	11,237	60.00
65.00	06500	RESPIRATORY THERAPY	0.482932	54,956	26,540	65.00
66.00	06600	PHYSICAL THERAPY	0.477594	128,892	61,558	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.548102	70,486	38,634	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.540244	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.394004	156,395	61,620	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.902202	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.758978	0	0	90.01
90.02	09002	SURGICAL CLINIC	2.609788	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.530951	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.285932	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		497,575	205,580	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)		497,575		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 5/18/2015 10:17 am

Title XIX | Hospital

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	54.00
60.00	06000	LABORATORY	0.000000	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000	0	0	90.01
90.02	09002	SURGICAL CLINIC	0.000000	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.000000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141327	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/18/2015 10:17 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6,029,847	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 Wkst. D, Pt. IV, col. 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)	6,029,847	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 Wkst. D-4, Pt. 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)	6,090,145	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)	50,246	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,655,506	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,384,393	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,384,393	30.00
31.00	Primary payer payments	135	31.00
32.00	Subtotal (line 30 minus line 31)	3,384,258	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	415,565	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	315,829	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	415,565	36.00
37.00	Subtotal (see instructions)	3,700,087	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,700,087	40.00
40.01	Sequestration adjustment (see instructions)	74,002	40.01
41.00	Interim payments	4,086,444	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-460,359	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I Date/Time Prepared: 5/18/2015 10:17 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		4,282,333		3,748,709	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		31,667		260,814	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	08/18/2014	266,646	08/18/2014	504,662	3.01
3.02		12/22/2014	77,088		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	12/22/2014	427,741	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)		343,734		76,921	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)		4,657,734		4,086,444	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		206,481		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		460,359	6.02
7.00	Total Medicare program liability (see instructions)		4,864,215		3,626,085	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: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 5/18/2015 10:17 am

Component CCN: 14Z327 | 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		609,199		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	12/22/2014	7,493		0	3.01
3.02		09/16/2014	389,121		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	08/18/2014	374,367		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)		22,247		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)		631,446		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		54,873		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		686,319		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: 141327	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 5/18/2015 10:17 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, Pt. I col. 15 line 14	657	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,663	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	80	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,377	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	65,284,585	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	64,306	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141327 Component CCN: 14Z327	Period: From 01/01/2014 To 12/31/2014	Worksheet E-2 Date/Time Prepared: 5/18/2015 10:17 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)	494,514	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	207,636	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	374	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)	702,150	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	702,150	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)	702,150	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,824	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)	700,326	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
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)	700,326	0	19.00
19.01	Sequestration adjustment (see instructions)	14,007	0	19.01
20.00	Interim payments	631,446	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)	54,873	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141327	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 5/18/2015 10:17 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	5,295,151	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	5,295,151	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	5,348,103	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)	5,348,103	19.00
20.00	Deductibles (exclude professional component)	419,092	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	4,929,011	22.00
23.00	Coinsurance	2,128	23.00
24.00	Subtotal (line 22 minus line 23)	4,926,883	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	48,161	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	36,602	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	48,161	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,963,485	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	4,963,485	30.00
30.01	Sequestration adjustment (see instructions)	99,270	30.01
31.00	Interim payments	4,657,734	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)	206,481	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 5/18/2015 10:17 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	2,346,837	0	0	0	1.00
2.00	Temporary investments	5,855,539	0	0	0	2.00
3.00	Notes receivable	18,529	0	0	0	3.00
4.00	Accounts receivable	17,775,776	0	0	0	4.00
5.00	Other receivable	12,548	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,140,940	0	0	0	6.00
7.00	Inventory	634,192	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	613,339	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	18,115,820	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	35,731,375	0	0	0	15.00
16.00	Accumulated depreciation	-20,960,720	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	14,770,655	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	469,545	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	469,545	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	33,356,020	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	713,157	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,085,180	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,081,170	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	3,451,558	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,331,065	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,270,000	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	6,270,000	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	12,601,065	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	20,754,955				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)	20,754,955	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	33,356,020	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 5/18/2015 10:17 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		19,364,208		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,583,103				2.00
3.00	Total (sum of line 1 and line 2)		20,947,311		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)		20,947,311		0		11.00
12.00	BOND COST ADJUSTMENT	192,356		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)		192,356		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		20,754,955		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	BOND COST ADJUSTMENT		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: 141327 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/18/2015 10:17 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,402,632		3,402,632	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,402,632		3,402,632	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	121,955		121,955	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)	121,955		121,955	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,524,587		3,524,587	17.00
18.00	Ancillary services	15,026,951	45,176,279	60,203,230	18.00
19.00	Outpatient services	0	547,239	547,239	19.00
20.00	RURAL HEALTH CLINIC	0	454,972	454,972	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,653,236	1,653,236	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	33,729	12,154,852	12,188,581	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	18,585,267	59,986,578	78,571,845	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,112,337		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	NON-OPERATING EXPENSES	4,845,208			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)		4,845,208		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		29,267,129		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141327	Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 5/18/2015 10:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	78,571,845	1.00
2.00	Less contractual allowances and discounts on patients' accounts	44,972,511	2.00
3.00	Net patient revenues (line 1 minus line 2)	33,599,334	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	29,267,129	4.00
5.00	Net income from service to patients (line 3 minus line 4)	4,332,205	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,930,023	24.00
24.01	NON-OPERATING DEDUCTIONS	4,293,319	24.01
25.00	Total other income (sum of lines 6-24)	6,223,342	25.00
26.00	Total (line 5 plus line 25)	10,555,547	26.00
27.00	NON-OPERATING G/L	750,554	27.00
27.01	NON-OPERATIN DEDUCTIONS	8,221,890	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	8,972,444	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,583,103	29.00

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

Provider CCN: 141327 Component CCN: 148501 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/18/2015 10:17 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	0	0	0	0	0	1.00
2.00	Physician Assistant	96,362	0	96,362	0	96,362	2.00
3.00	Nurse Practitioner	8,256	0	8,256	0	8,256	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	59,602	0	59,602	0	59,602	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 through 9)	164,220	0	164,220	0	164,220	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	3,622	3,622	-1,541	2,081	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	3,622	3,622	-1,541	2,081	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	164,220	3,622	167,842	-1,541	166,301	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 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	38,915	38,915	0	38,915	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	38,915	38,915	0	38,915	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	164,220	42,537	206,757	-1,541	205,216	32.00

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

Provider CCN: 141327 | Component CCN: 148501 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 5/18/2015 10:17 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	0		1.00
2.00	Physician Assistant	0	96,362		2.00
3.00	Nurse Practitioner	0	8,256		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	59,602		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 through 9)	0	164,220		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	2,081		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,081		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	166,301		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 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	38,915		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	38,915		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	205,216		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141327 | Component CCN: 148501 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-2 | Date/Time Prepared: 5/18/2015 10:17 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	0.00	23	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.90	4,817	2,100	1,890		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.90	4,840		1,890	4,840	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 through 7)	0.90	4,840			4,840	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					166,301	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					166,301	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 Wkst. M-1, col. 7, line 31)					38,915	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					194,061	15.00
16.00	Total overhead (sum of lines 14 and 15)					232,976	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					232,976	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					232,976	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					399,277	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141327 | Component CCN: 148501 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-3 | Date/Time Prepared: 5/18/2015 10:17 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 Wkst. M-2, line 20)		399,277	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		399,277	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		4,840	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		4,840	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		82.50	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	82.50	82.50	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	292	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	24,090	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) *		24,090	16.00
16.01	Total program charges (see instructions)(from contractor's records)		30,258	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		15,514	16.04
16.05	Total program cost (see instructions)		15,514	16.05
17.00	Primary payer amounts		61	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,697	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,112	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		15,453	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		15,453	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
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		15,453	26.00
26.01	Sequestration adjustment (see instructions)		309	26.01
27.00	Interim payments		14,331	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)		813	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

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

Provider CCN: 141327 Component CCN: 148501 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-5 | Date/Time Prepared: 5/18/2015 10:17 am

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		12,863	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		12/22/2014	1,468	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1,468	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		14,331	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		813	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		15,144	7.00

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