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: 141329	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 10/28/2014 7:19 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 10/28/2014 Time: 7:19 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MORRISON COMMUNITY HOSPITAL (141329) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	34,434	144,395	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	195,923	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-6,183		0	10.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	230,357	138,212	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 10/27/2014 9:36 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 JACKSON	PO Box:			1.00
2.00	City: MORRISON	State: IL	Zip Code: 61270	County: WHITESIDE	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	MORRISON COMMUNITY HOSPITAL	141329	99914	1	08/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MORRISON SWING BED	14Z329	99914		08/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	MORRISON SNF	145274	99914		08/13/1974	N	P	O	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	MORRISON COMMUNITY HOSPITAL CLINIC	143981	99914		07/01/1996	N	O	O	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2013	06/30/2014	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 10/27/2014 9:36 am

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 10/27/2014 9:36 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings		
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141329	Period: From 07/01/2013 To 06/30/2014	Worksheet S-2 Part I Date/Time Prepared: 10/27/2014 9:36 am

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

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

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	237,330	0	0	118.01

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

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

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 10/27/2014 9:36 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	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	09/08/2014	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 10/27/2014 9:36 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				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404	DAN.LINHART@MCGLADREY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 10/27/2014 9:36 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	09/08/2014			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		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: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 10/27/2014 9:36 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	25	9,125	3,000.00	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)		25	9,125	3,000.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	3,000.00	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	44.00	38	13,870		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC	99.00				0	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)		63				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: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 10/27/2014 9:36 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)	83	19	125			1.00
2.00	HMO and other (see instructions)	10	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	1,835	0	2,105			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	331			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,918	19	2,561			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,918	19	2,561	0.00	102.19	14.00
15.00	CAH visits	1,951	1,100	5,938			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	4,611	9,678	0.00	20.96	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	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	0	0	0	0.00	0.00	25.00
26.00	RURAL HEALTH CLINIC	1,271	3,019	12,054	0.00	10.02	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	133.17	27.00
28.00	Observation Bed Days		13	108			28.00
29.00	Ambulance Trips	270					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: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 10/27/2014 9:36 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	29	8	62	1.00
2.00	HMO and other (see instructions)			7			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	29	8	62	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	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC	0.00					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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-7 | Date/Time Prepared: 10/27/2014 9:36 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	Y		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	08/01/2003	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	0	0	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-7 | Date/Time Prepared: 10/27/2014 9:36 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914		201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	655,436	37.72	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,737,766			207.00

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

Provider CCN: 141329 Component CCN: 143981 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-8 | Date/Time Prepared: 10/27/2014 9:36 am

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			300 NORTH JACKSON STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	MORRISON		IL	61270	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic	08:00	20:00	08:00	20:00	08:00	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N	0	13.00
			Provider name		CCN number	
			1.00		2.00	
14.00	Provider name, CCN number					14.00

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

			County				
			4.00				
2.00	City, State, Zip Code, County		WHITESIDE				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	20:00	08:00	20:00	08:00	20:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141329 Component CCN: 143981	Period: From 07/01/2013 To 06/30/2014	Worksheet S-8 Date/Time Prepared: 10/27/2014 9:36 am

		Rural Health Clinic (RHC) I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	20:00	08:00	20:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-10 | Date/Time Prepared: 10/27/2014 9:36 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)	0.822444	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,191,592	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	2,334,111	6.00
7.00	Medicaid cost (line 1 times line 6)	1,919,676	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)	728,084	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)	728,084	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	45,488	22,138	67,626	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	37,411	18,207	55,618	21.00
22.00	Partial payment by patients approved for charity care	2,730	2,812	5,542	22.00
23.00	Cost of charity care (line 21 minus line 22)	34,681	15,395	50,076	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)	884,989	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	57,035	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	827,954	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	680,946	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	731,022	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,459,106	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 10/27/2014 9:36 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		506,513	506,513	-123,472	383,041	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		23,875	23,875	298,674	322,549	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,316,517	1,316,517	0	1,316,517	4.00
5.01	00560	PURCHASING	41,324	6,872	48,196	0	48,196	5.01
5.02	00591	PERSONNEL	94,393	19,528	113,921	0	113,921	5.02
5.03	00580	HOSPITAL BILLING	245,537	104,962	350,499	0	350,499	5.03
5.04	00581	NURSING HOME BILLING	538	229	767	0	767	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	330,453	611,326	941,779	163,410	1,105,189	5.05
7.00	00700	OPERATION OF PLANT	148,597	383,502	532,099	0	532,099	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,633	44,633	0	44,633	8.00
9.00	00900	HOUSEKEEPING	168,991	37,638	206,629	0	206,629	9.00
10.00	01000	DIETARY	200,893	126,114	327,007	0	327,007	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	116,394	1,475	117,869	0	117,869	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,749	19,966	36,715	0	36,715	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	194,987	31,692	226,679	0	226,679	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	261	44	305	0	305	16.01
17.00	01700	SOCIAL SERVICE	67,264	588	67,852	0	67,852	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,032,983	164,548	1,197,531	-2,700	1,194,831	30.00
44.00	04400	SKILLED NURSING FACILITY	690,294	53,892	744,186	-7,469	736,717	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	32,211	162,843	195,054	-19,080	175,974	50.00
53.00	05300	ANESTHESIOLOGY	0	26,192	26,192	0	26,192	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	230,895	75,575	306,470	5,925	312,395	54.00
60.00	06000	LABORATORY	284,796	259,117	543,913	0	543,913	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	31,947	31,947	-8,226	23,721	65.00
66.00	06600	PHYSICAL THERAPY	238,392	8,775	247,167	0	247,167	66.00
67.00	06700	OCCUPATIONAL THERAPY	188,673	1,108	189,781	0	189,781	67.00
68.00	06800	SPEECH PATHOLOGY	3,202	2,875	6,077	0	6,077	68.00
69.00	06900	ELECTROCARDIOLOGY	2,613	6,944	9,557	0	9,557	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	22,264	22,264	18,395	40,659	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,560	19,560	19,080	38,640	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	127,211	221,204	348,415	0	348,415	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	547,768	1,028,088	1,575,856	-563,366	1,012,490	88.00
91.00	09100	EMERGENCY	353,750	666,448	1,020,198	367,166	1,387,364	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	105,349	37,390	142,739	-5,296	137,443	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		143,041	143,041	-143,041	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,464,518	6,167,285	11,631,803	0	11,631,803	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	4,375	11,489	15,864	0	15,864	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	5,468,893	6,178,774	11,647,667	0	11,647,667	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 10/27/2014 9:36 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,966	381,075		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-2,322	320,227		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,421	1,313,096		4.00
5.01	00560	PURCHASING	0	48,196		5.01
5.02	00591	PERSONNEL	0	113,921		5.02
5.03	00580	HOSPITAL BILLING	-9,049	341,450		5.03
5.04	00581	NURSING HOME BILLING	0	767		5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	-61,652	1,043,537		5.05
7.00	00700	OPERATION OF PLANT	0	532,099		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,633		8.00
9.00	00900	HOUSEKEEPING	0	206,629		9.00
10.00	01000	DIETARY	-21,806	305,201		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	117,869		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	36,715		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,716	223,963		16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	305		16.01
17.00	01700	SOCIAL SERVICE	0	67,852		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,011	1,192,820		30.00
44.00	04400	SKILLED NURSING FACILITY	0	736,717		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-80,530	95,444		50.00
53.00	05300	ANESTHESIOLOGY	-2,951	23,241		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-11,087	301,308		54.00
60.00	06000	LABORATORY	-36,256	507,657		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-29	23,692		65.00
66.00	06600	PHYSICAL THERAPY	-4,525	242,642		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	189,781		67.00
68.00	06800	SPEECH PATHOLOGY	0	6,077		68.00
69.00	06900	ELECTROCARDIOLOGY	-5,250	4,307		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-15	40,644		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	-739	37,901		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-2,076	346,339		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-47,473	965,017		88.00
91.00	09100	EMERGENCY	-116,518	1,270,846		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-187	137,256		95.00
99.00	09900	CMHC	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-412,579	11,219,224		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OPTH CLINIC	0	15,864		194.00
194.01	07951	RENTAL SPACE	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-412,579	11,235,088		200.00

RECLASSIFICATIONS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 10/27/2014 9:36 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	124,077		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	10,730		2.00
3.00	AMBULANCE SERVICES	95.00	0	2,309		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,925		4.00
	TOTALS		0	143,041		
	B - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	40,424		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	10,701		2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	152,680		3.00
	TOTALS		0	203,805		
	C - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	287,973		1.00
	TOTALS		0	287,973		
	D - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	19,080		1.00
	TOTALS		0	19,080		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	18,395		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	TOTALS		0	18,395		
	F - ACTIVITIES DIRECTOR					
1.00	ADULTS & PEDIATRICS	30.00	3,709	225		1.00
	TOTALS		3,709	225		
	G - RHC PHYS IN ER					
1.00	EMERGENCY	91.00	0	465,266		1.00
	TOTALS		0	465,266		
500.00	Grand Total: Increases		3,709	1,137,785		500.00

RECLASSIFICATIONS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 10/27/2014 9:36 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	143,041	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	143,041			
	B - INSURANCE						
1.00	EMERGENCY	91.00	0	98,100	12		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	98,100	12		2.00
3.00	AMBULANCE SERVICES	95.00	0	7,605	0		3.00
	TOTALS		0	203,805			
	C - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	287,973	9		1.00
	TOTALS		0	287,973			
	D - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	19,080	0		1.00
	TOTALS		0	19,080			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	6,634	0		1.00
2.00	SKILLED NURSING FACILITY	44.00	0	3,535	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	8,226	0		3.00
	TOTALS		0	18,395			
	F - ACTIVITIES DIRECTOR						
1.00	SKILLED NURSING FACILITY	44.00	3,709	225	0		1.00
	TOTALS		3,709	225			
	G - RHC PHYS IN ER						
1.00	RURAL HEALTH CLINIC	88.00	0	465,266	0		1.00
	TOTALS		0	465,266			
500.00	Grand Total: Decreases		3,709	1,137,785			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 10/27/2014 9:36 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	21,657	0	0	0	0	1.00
2.00	Land Improvements	362,300	0	0	0	0	2.00
3.00	Buildings and Fixtures	4,445,725	32,312	0	32,312	0	3.00
4.00	Building Improvements	3,329,068	9,730	0	9,730	0	4.00
5.00	Fixed Equipment	328,274	0	0	0	0	5.00
6.00	Movable Equipment	3,933,557	155,368	0	155,368	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,420,581	197,410	0	197,410	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	12,420,581	197,410	0	197,410	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	21,657	0	1.00
2.00	Land Improvements	362,300	0	2.00
3.00	Buildings and Fixtures	4,478,037	0	3.00
4.00	Building Improvements	3,338,798	0	4.00
5.00	Fixed Equipment	328,274	0	5.00
6.00	Movable Equipment	4,088,925	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,617,991	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	12,617,991	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part II Date/Time Prepared: 10/27/2014 9:36 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	506,513	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	23,875	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	530,388	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	506,513	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	23,875	2.00
3.00	Total (sum of lines 1-2)	0	530,388	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 10/27/2014 9:36 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	8,529,065	0	8,529,065	0.675945	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,088,925	0	4,088,925	0.324055	0	2.00
3.00	Total (sum of lines 1-2)	12,617,990	0	12,617,990	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	218,540	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	309,526	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	528,066	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	122,111	40,424	0	0	381,075	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	10,701	0	0	320,227	2.00
3.00	Total (sum of lines 1-2)	122,111	51,125	0	0	701,302	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 10/27/2014 9:36 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,966	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,888	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	7.00
8.00	Television and radio service (chapter 21)	A	-2,322	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-159,947			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-20,998	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-2,716	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 10/27/2014 9:36 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	
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	LAB OTHER REVENUE	B	-20,466	LABORATORY	60.00	0	33.00
33.01	REHAB MISC REV	B	-1,910	PHYSICAL THERAPY	66.00	0	33.01
33.02	INVESTMENT INCOME-OTHER	B	-170	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.02
33.03	INVESTMENT INCOME-OTHER	B	-37	AMBULANCE SERVICES	95.00	0	33.03
33.04	INVESTMENT INCOME-OTHER	B	-94	RADIOLOGY-DIAGNOSTIC	54.00	0	33.04
33.05			0		0.00	0	33.05
33.06	OTHER REV -A&G	B	-1,725	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.06
33.07	OTHER REV - DIETARY	B	-808	DIETARY	10.00	0	33.07
33.08	OTHER REV - AMBULANCE	B	-150	AMBULANCE SERVICES	95.00	0	33.08
33.09	OTHER REV - PHYSICAL THERAPY	B	-55	PHYSICAL THERAPY	66.00	0	33.09
34.00	NONALLOWABLE DUES	A	-5,054	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	34.00
35.00	PATIENT TELEPHONE - SALARIES	A	-5,158	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	35.00
36.00	PATIENT TELEPHONE - BENEFITS	A	-1,243	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
37.00	PHYSICIAN BILLING SALARIES	A	-9,049	HOSPITAL BILLING	5.03	0	37.00
38.00	PHYSICIAN BILLING EMPLOYEE BENEFITS	A	-2,178	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	ADVERTISING	A	-46,582	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	39.00
41.00	OTHER REV- EDUCATION	A	-75	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	41.00
42.00			0		0.00	0	42.00
43.00	SELF INSURANCE EXPENSE	A	-58,871	OPERATING ROOM	50.00	0	43.00
44.00	SELF INSURANCE EXPENSE	A	-2,951	ANESTHESIOLOGY	53.00	0	44.00
45.00	SELF INSURANCE EXPENSE	A	-10,993	RADIOLOGY-DIAGNOSTIC	54.00	0	45.00
45.01	SELF INSURANCE EXPENSE	A	-15,111	LABORATORY	60.00	0	45.01
45.02	SELF INSURANCE EXPENSE	A	-679	LABORATORY	60.00	0	45.02
45.03	SELF INSURANCE EXPENSE	A	-29	RESPIRATORY THERAPY	65.00	0	45.03
45.04	SELF INSURANCE EXPENSE	A	-2,560	PHYSICAL THERAPY	66.00	0	45.04
45.05			0		0.00	0	45.05
45.06	SELF INSURANCE EXPENSE	A	-107	ELECTROCARDIOLOGY	69.00	0	45.06
45.07	SELF INSURANCE EXPENSE	A	-15	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	45.07
45.08	SELF INSURANCE EXPENSE	A	-739	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	45.08
45.09	SELF INSURANCE EXPENSE	A	-2,076	DRUGS CHARGED TO PATIENTS	73.00	0	45.09
45.11	SELF INSURANCE EXPENSE	A	-3,946	EMERGENCY	91.00	0	45.11
45.12	SELF INSURANCE EXPENSE	A	-2,011	ADULTS & PEDIATRICS	30.00	0	45.12
45.13	SELF INSURANCE EXPENSE	A	-26,900	RURAL HEALTH CLINIC	88.00	0	45.13
45.15			0		0.00	0	45.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-412,579				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 10/27/2014 9:36 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	91.00	EMERGENCY	983,509	112,572	870,937	0	0	1.00
2.00	91.00	EMERGENCY	6,300	0	6,300	0	0	2.00
3.00	50.00	OPERATING ROOM	21,659	21,659	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	5,143	5,143	0	0	0	4.00
5.00	88.00	RURAL HEALTH CLINIC	20,573	20,573	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,037,184	159,947	877,237		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	112,572		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	50.00	OPERATING ROOM	0	0	0	21,659		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	5,143		4.00
5.00	88.00	RURAL HEALTH CLINIC	0	0	0	20,573		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	159,947		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 10/27/2014 9:36 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	PURCHASING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	381,075	381,075				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	320,227		320,227			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,313,096	0	0	1,313,096		4.00
5.01	00560	PURCHASING	48,196	11,100	0	9,922	69,218	5.01
5.02	00591	PERSONNEL	113,921	3,530	0	22,664	1,112	5.02
5.03	00580	HOSPITAL BILLING	341,450	6,095	0	58,954	2,426	5.03
5.04	00581	NURSING HOME BILLING	767	617	0	129	0	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	1,043,537	18,389	19,516	79,343	5,156	5.05
7.00	00700	OPERATION OF PLANT	532,099	68,621	5,482	35,679	2,595	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,633	8,738	0	0	404	8.00
9.00	00900	HOUSEKEEPING	206,629	3,648	0	40,575	1,516	9.00
10.00	01000	DIETARY	305,201	10,110	244	48,235	1,078	10.00
11.00	01100	CAFETERIA	0	3,890	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	117,869	5,163	0	27,947	202	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	36,715	3,411	0	4,021	13,819	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	223,963	8,030	612	46,817	977	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	305	656	0	63	0	16.01
17.00	01700	SOCIAL SERVICE	67,852	1,004	0	16,150	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,192,820	61,406	37,371	248,911	4,752	30.00
44.00	04400	SKILLED NURSING FACILITY	736,717	57,863	660	164,851	3,572	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	95,444	13,744	84,944	7,734	2,325	50.00
53.00	05300	ANESTHESIOLOGY	23,241	0	0	0	202	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	301,308	9,139	82,925	55,439	1,887	54.00
60.00	06000	LABORATORY	507,657	9,224	15,543	68,380	4,583	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	23,692	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	242,642	9,506	757	57,239	1,988	66.00
67.00	06700	OCCUPATIONAL THERAPY	189,781	3,247	0	45,301	0	67.00
68.00	06800	SPEECH PATHOLOGY	6,077	0	0	769	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,307	0	3,409	627	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,644	0	0	0	2,730	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,901	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	346,339	3,175	6,130	30,544	505	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	965,017	34,062	5,999	131,521	8,088	88.00
91.00	09100	EMERGENCY	1,270,846	8,207	7,480	84,936	6,133	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	137,256	18,500	49,155	25,295	3,168	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,219,224	381,075	320,227	1,312,046	69,218	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	15,864	0	0	1,050	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	11,235,088	381,075	320,227	1,313,096	69,218	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 10/27/2014 9:36 am

		Cost Center Description	PERSONNEL	HOSPITAL BILLING	NURSING HOME BILLING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL	141,227					5.02
5.03	00580	HOSPITAL BILLING	6,502	415,427				5.03
5.04	00581	NURSING HOME BILLING	14	0	1,527			5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	8,751	0	0	1,174,692	1,174,692	5.05
7.00	00700	OPERATION OF PLANT	3,935	0	0	648,411	75,711	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	53,775	6,279	8.00
9.00	00900	HOUSEKEEPING	4,475	0	0	256,843	29,990	9.00
10.00	01000	DIETARY	5,320	0	0	370,188	43,225	10.00
11.00	01100	CAFETERIA	0	0	0	3,890	454	11.00
13.00	01300	NURSING ADMINISTRATION	3,082	0	0	154,263	18,012	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	444	0	0	58,410	6,820	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,163	0	0	285,562	33,343	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	7	0	0	1,031	120	16.01
17.00	01700	SOCIAL SERVICE	1,781	0	0	86,787	10,134	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,452	50,591	0	1,623,303	189,544	30.00
44.00	04400	SKILLED NURSING FACILITY	18,181	0	1,527	983,371	114,822	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	853	14,800	0	219,844	25,670	50.00
53.00	05300	ANESTHESIOLOGY	0	1,531	0	24,974	2,916	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,114	63,596	0	520,408	60,765	54.00
60.00	06000	LABORATORY	7,542	66,605	0	679,534	79,345	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,429	0	26,121	3,050	65.00
66.00	06600	PHYSICAL THERAPY	6,313	33,242	0	351,687	41,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,996	21,575	0	264,900	30,931	67.00
68.00	06800	SPEECH PATHOLOGY	85	683	0	7,614	889	68.00
69.00	06900	ELECTROCARDIOLOGY	69	2,893	0	11,305	1,320	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,023	0	53,397	6,235	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	704	0	38,605	4,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,369	49,077	0	439,139	51,276	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,505	55,734	0	1,214,926	141,860	88.00
91.00	09100	EMERGENCY	9,368	22,833	0	1,409,803	164,614	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,790	19,111	0	255,275	29,807	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	141,111	415,427	1,527	11,218,058	1,172,704	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	116	0	0	17,030	1,988	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	141,227	415,427	1,527	11,235,088	1,174,692	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 10/27/2014 9:36 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	HOSPITAL BILLING						5.03
5.04	00581	NURSING HOME BILLING						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	724,122					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,202	83,256				8.00
9.00	00900	HOUSEKEEPING	9,685	0	296,518			9.00
10.00	01000	DIETARY	26,843	0	1,596	441,852		10.00
11.00	01100	CAFETERIA	10,329	0	0	83,822	98,495	11.00
13.00	01300	NURSING ADMINISTRATION	13,709	0	3,463	0	1,825	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,058	0	5,030	0	485	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	21,321	0	5,388	0	5,093	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	1,742	0	967	0	10	16.01
17.00	01700	SOCIAL SERVICE	2,665	0	1,480	0	1,031	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	163,040	28,774	88,983	76,548	24,732	30.00
44.00	04400	SKILLED NURSING FACILITY	153,635	41,275	82,144	281,238	21,608	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,493	428	13,378	0	670	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,265	1,888	11,927	0	4,732	54.00
60.00	06000	LABORATORY	24,491	0	13,600	0	6,093	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	25,240	1,214	14,016	0	3,464	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,622	0	4,788	0	2,082	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	31	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	10	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,431	0	3,927	0	1,804	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	90,439	1,316	33,730	0	10,330	88.00
91.00	09100	EMERGENCY	21,791	7,660	12,101	0	11,650	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	49,121	701	0	0	2,845	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	724,122	83,256	296,518	441,608	98,495	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	244	0	194.02
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)	724,122	83,256	296,518	441,852	98,495	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 10/27/2014 9:36 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NURSING HOME MEDICAL RECORDS & LIBR	SOCIAL SERVICE	
			13.00	14.00	16.00	16.01	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	HOSPITAL BILLING						5.03
5.04	00581	NURSING HOME BILLING						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	191,272					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	79,803				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	350,707			16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	0	0	3,870		16.01
17.00	01700	SOCIAL SERVICE	3,373	0	0	0	105,470	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	80,680	357	42,710	0	92,937	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	3,870	12,533	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,183	50,524	12,494	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	1,293	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	53,689	0	0	54.00
60.00	06000	LABORATORY	0	0	56,223	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	2,051	0	0	65.00
66.00	06600	PHYSICAL THERAPY	11,307	0	28,063	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,778	0	18,214	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	94	0	577	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,443	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	8,462	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	594	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,882	0	41,432	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	33,685	23,120	47,052	0	0	88.00
91.00	09100	EMERGENCY	38,001	5,802	19,276	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	9,289	0	16,134	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	191,272	79,803	350,707	3,870	105,470	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	191,272	79,803	350,707	3,870	105,470	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 10/27/2014 9:36 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	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING					5.01
5.02	00591	PERSONNEL					5.02
5.03	00580	HOSPITAL BILLING					5.03
5.04	00581	NURSING HOME BILLING					5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR					16.01
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,411,608	-17,712	2,393,896		30.00
44.00	04400	SKILLED NURSING FACILITY	1,694,496	0	1,694,496		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	361,684	0	361,684		50.00
53.00	05300	ANESTHESIOLOGY	29,183	0	29,183		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	677,674	0	677,674		54.00
60.00	06000	LABORATORY	859,286	0	859,286		60.00
64.00	06400	INTRAVENOUS THERAPY	0	33,278	33,278		64.00
65.00	06500	RESPIRATORY THERAPY	31,222	0	31,222		65.00
66.00	06600	PHYSICAL THERAPY	476,055	0	476,055		66.00
67.00	06700	OCCUPATIONAL THERAPY	336,315	0	336,315		67.00
68.00	06800	SPEECH PATHOLOGY	9,205	0	9,205		68.00
69.00	06900	ELECTROCARDIOLOGY	15,078	0	15,078		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,094	0	68,094		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,707	0	43,707		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	551,891	-15,567	536,324		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1,596,458	0	1,596,458		88.00
91.00	09100	EMERGENCY	1,690,698	0	1,690,698		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	363,172	0	363,172		95.00
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,215,826	0	11,215,825		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
194.00	07950	OPTH CLINIC	19,018	0	19,018		194.00
194.01	07951	RENTAL SPACE	0	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	244	0	244		194.02
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)	11,235,088	0	11,235,087		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 10/27/2014 9:36 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00560	PURCHASING	0	11,100	0	11,100	0	5.01
5.02	00591	PERSONNEL	0	3,530	0	3,530	0	5.02
5.03	00580	HOSPITAL BILLING	597	6,095	0	6,692	0	5.03
5.04	00581	NURSING HOME BILLING	1	617	0	618	0	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	0	18,389	19,516	37,905	0	5.05
7.00	00700	OPERATION OF PLANT	336	68,621	5,482	74,439	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	8,738	0	8,738	0	8.00
9.00	00900	HOUSEKEEPING	0	3,648	0	3,648	0	9.00
10.00	01000	DIETARY	1,065	10,110	244	11,419	0	10.00
11.00	01100	CAFETERIA	0	3,890	0	3,890	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,163	0	5,163	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,411	0	3,411	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,245	8,030	612	10,887	0	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	3	656	0	659	0	16.01
17.00	01700	SOCIAL SERVICE	0	1,004	0	1,004	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,896	61,406	37,371	134,673	0	30.00
44.00	04400	SKILLED NURSING FACILITY	814	57,863	660	59,337	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,243	13,744	84,944	149,931	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,000	9,139	82,925	104,064	0	54.00
60.00	06000	LABORATORY	0	9,224	15,543	24,767	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	23,721	0	0	23,721	0	65.00
66.00	06600	PHYSICAL THERAPY	120	9,506	757	10,383	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,247	0	3,247	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,409	3,409	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,432	3,175	6,130	15,737	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	16,370	34,062	5,999	56,431	0	88.00
91.00	09100	EMERGENCY	6,578	8,207	7,480	22,265	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	18,500	49,155	67,655	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	157,421	381,075	320,227	858,723	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	157,421	381,075	320,227	858,723	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 10/27/2014 9:36 am

		Cost Center Description	PURCHASING	PERSONNEL	HOSPITAL BILLING	NURSING HOME BILLING	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING	11,100					5.01
5.02	00591	PERSONNEL	178	3,708				5.02
5.03	00580	HOSPITAL BILLING	389	171	7,252			5.03
5.04	00581	NURSING HOME BILLING	0	0	0	618		5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	827	230	0	0	38,962	5.05
7.00	00700	OPERATION OF PLANT	416	103	0	0	2,511	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	65	0	0	0	208	8.00
9.00	00900	HOUSEKEEPING	243	117	0	0	995	9.00
10.00	01000	DIETARY	173	140	0	0	1,434	10.00
11.00	01100	CAFETERIA	0	0	0	0	15	11.00
13.00	01300	NURSING ADMINISTRATION	32	81	0	0	597	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,215	12	0	0	226	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	157	136	0	0	1,106	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	0	0	0	4	16.01
17.00	01700	SOCIAL SERVICE	0	47	0	0	336	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	762	722	883	0	6,285	30.00
44.00	04400	SKILLED NURSING FACILITY	573	477	0	618	3,809	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	373	22	258	0	851	50.00
53.00	05300	ANESTHESIOLOGY	32	0	27	0	97	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	303	160	1,110	0	2,016	54.00
60.00	06000	LABORATORY	735	198	1,165	0	2,632	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	42	0	101	65.00
66.00	06600	PHYSICAL THERAPY	319	166	580	0	1,362	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	131	377	0	1,026	67.00
68.00	06800	SPEECH PATHOLOGY	0	2	12	0	29	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2	50	0	44	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	438	0	175	0	207	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	12	0	150	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	81	88	856	0	1,701	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,297	381	973	0	4,705	88.00
91.00	09100	EMERGENCY	984	246	398	0	5,460	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	508	73	334	0	989	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,100	3,705	7,252	618	38,896	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	3	0	0	66	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	11,100	3,708	7,252	618	38,962	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 10/27/2014 9:36 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	HOSPITAL BILLING						5.03
5.04	00581	NURSING HOME BILLING						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	77,469					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,482	11,493				8.00
9.00	00900	HOUSEKEEPING	1,036	0	6,039			9.00
10.00	01000	DIETARY	2,872	0	33	16,071		10.00
11.00	01100	CAFETERIA	1,105	0	0	3,049	8,059	11.00
13.00	01300	NURSING ADMINISTRATION	1,467	0	71	0	149	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	969	0	102	0	40	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,281	0	110	0	417	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	186	0	20	0	1	16.01
17.00	01700	SOCIAL SERVICE	285	0	30	0	84	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,445	3,972	1,812	2,784	2,023	30.00
44.00	04400	SKILLED NURSING FACILITY	16,436	5,697	1,673	10,229	1,768	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,904	59	272	0	55	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,596	261	243	0	387	54.00
60.00	06000	LABORATORY	2,620	0	277	0	499	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,700	168	285	0	283	66.00
67.00	06700	OCCUPATIONAL THERAPY	922	0	98	0	170	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	3	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	902	0	80	0	148	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,675	182	687	0	845	88.00
91.00	09100	EMERGENCY	2,331	1,057	246	0	953	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,255	97	0	0	233	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	77,469	11,493	6,039	16,062	8,059	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	9	0	194.02
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)	77,469	11,493	6,039	16,071	8,059	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 10/27/2014 9:36 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NURSING HOME MEDICAL RECORDS & LIBR	SOCIAL SERVICE	
			13.00	14.00	16.00	16.01	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	HOSPITAL BILLING						5.03
5.04	00581	NURSING HOME BILLING						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	7,560					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,975				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	15,094			16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	0	0	870		16.01
17.00	01700	SOCIAL SERVICE	133	0	0	0	1,919	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,190	31	1,838	0	1,691	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	870	228	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	86	4,416	538	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	56	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,310	0	0	54.00
60.00	06000	LABORATORY	0	0	2,423	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	88	0	0	65.00
66.00	06600	PHYSICAL THERAPY	447	0	1,207	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	268	0	784	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4	0	25	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	105	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	364	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	26	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	232	0	1,783	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,331	2,021	2,024	0	0	88.00
91.00	09100	EMERGENCY	1,502	507	829	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	367	0	694	0	0	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,560	6,975	15,094	870	1,919	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	7,560	6,975	15,094	870	1,919	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 10/27/2014 9:36 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	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING					5.01
5.02	00591	PERSONNEL					5.02
5.03	00580	HOSPITAL BILLING					5.03
5.04	00581	NURSING HOME BILLING					5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL					5.05
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR					16.01
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	178,111	0	178,111		30.00
44.00	04400	SKILLED NURSING FACILITY	101,715	0	101,715		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	160,765	0	160,765		50.00
53.00	05300	ANESTHESIOLOGY	212	0	212		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,450	0	113,450		54.00
60.00	06000	LABORATORY	35,316	0	35,316		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	23,952	0	23,952		65.00
66.00	06600	PHYSICAL THERAPY	17,900	0	17,900		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,023	0	7,023		67.00
68.00	06800	SPEECH PATHOLOGY	75	0	75		68.00
69.00	06900	ELECTROCARDIOLOGY	3,611	0	3,611		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,184	0	1,184		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	188	0	188		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,608	0	21,608		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	80,552	0	80,552		88.00
91.00	09100	EMERGENCY	36,778	0	36,778		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	76,205	0	76,205		95.00
99.00	09900	CMHC	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	858,645	0	858,645		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
194.00	07950	OPTH CLINIC	69	0	69		194.00
194.01	07951	RENTAL SPACE	0	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	9	0	9		194.02
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)	858,723	0	858,723		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 10/27/2014 9:36 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING (PURCHASE ORDERS)	PERSONNEL (GROSS SALARIES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	58,087					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		287,930				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,468,893			4.00
5.01	00560	PURCHASING	1,692	0	41,324	2,054		5.01
5.02	00591	PERSONNEL	538	0	94,393	33	5,333,176	5.02
5.03	00580	HOSPITAL BILLING	929	0	245,537	72	245,537	5.03
5.04	00581	NURSING HOME BILLING	94	0	538	0	538	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	2,803	17,548	330,453	153	330,453	5.05
7.00	00700	OPERATION OF PLANT	10,460	4,929	148,597	77	148,597	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,332	0	0	12	0	8.00
9.00	00900	HOUSEKEEPING	556	0	168,991	45	168,991	9.00
10.00	01000	DIETARY	1,541	219	200,893	32	200,893	10.00
11.00	01100	CAFETERIA	593	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	787	0	116,394	6	116,394	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	16,749	410	16,749	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,224	550	194,987	29	194,987	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	100	0	261	0	261	16.01
17.00	01700	SOCIAL SERVICE	153	0	67,264	0	67,264	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,360	33,602	1,036,692	141	1,036,692	30.00
44.00	04400	SKILLED NURSING FACILITY	8,820	593	686,585	106	686,585	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,095	76,378	32,211	69	32,211	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,393	74,561	230,895	56	230,895	54.00
60.00	06000	LABORATORY	1,406	13,975	284,796	136	284,796	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,449	681	238,392	59	238,392	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	188,673	0	188,673	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	3,202	0	3,202	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,065	2,613	0	2,613	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	81	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	484	5,512	127,211	15	127,211	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,192	5,394	547,768	240	547,768	88.00
91.00	09100	EMERGENCY	1,251	6,726	353,750	182	353,750	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,820	44,197	105,349	94	105,349	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,087	287,930	5,464,518	2,054	5,328,801	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	4,375	0	4,375	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	381,075	320,227	1,313,096	69,218	141,227	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.560418	1.112170	0.240103	33.699124	0.026481	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	11,100	3,708	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	5.404090	0.000695	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 10/27/2014 9:36 am

		Cost Center Description	HOSPITAL BILLING (NON-NURSIN G HOME CH)	NURSING HOME BILLING (NURSING HO ME CHARGE)	Reconciliatio n	OTHER ADMINISTRATIV E AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	HOSPITAL BILLING	11,807,308					5.03
5.04	00581	NURSING HOME BILLING	0	1,737,766				5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	-1,174,692	10,060,396		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	648,411	41,571	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	53,775	1,332	8.00
9.00	00900	HOUSEKEEPING	0	0	0	256,843	556	9.00
10.00	01000	DIETARY	0	0	0	370,188	1,541	10.00
11.00	01100	CAFETERIA	0	0	0	3,890	593	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	154,263	787	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	58,410	520	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	285,562	1,224	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	0	0	1,031	100	16.01
17.00	01700	SOCIAL SERVICE	0	0	0	86,787	153	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,437,895	0	0	1,623,303	9,360	30.00
44.00	04400	SKILLED NURSING FACILITY	0	1,737,766	0	983,371	8,820	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	420,632	0	0	219,844	2,095	50.00
53.00	05300	ANESTHESIOLOGY	43,524	0	0	24,974	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,807,512	0	0	520,408	1,393	54.00
60.00	06000	LABORATORY	1,893,113	0	0	679,534	1,406	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	69,034	0	0	26,121	0	65.00
66.00	06600	PHYSICAL THERAPY	944,802	0	0	351,687	1,449	66.00
67.00	06700	OCCUPATIONAL THERAPY	613,214	0	0	264,900	495	67.00
68.00	06800	SPEECH PATHOLOGY	19,420	0	0	7,614	0	68.00
69.00	06900	ELECTROCARDIOLOGY	82,237	0	0	11,305	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	284,879	0	0	53,397	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,001	0	0	38,605	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,394,861	0	0	439,139	484	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,584,074	0	0	1,214,926	5,192	88.00
91.00	09100	EMERGENCY	648,947	0	0	1,409,803	1,251	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	543,163	0	0	255,275	2,820	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,807,308	1,737,766	-1,174,692	10,043,366	41,571	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	17,030	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	415,427	1,527		1,174,692	724,122	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.035184	0.000879		0.116764	17.418922	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,252	618		38,962	77,469	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000614	0.000356		0.003873	1.863535	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 10/27/2014 9:36 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	HOSPITAL BILLING						5.03
5.04	00581	NURSING HOME BILLING						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,564					8.00
9.00	00900	HOUSEKEEPING	0	30,654				9.00
10.00	01000	DIETARY	0	165	45,312			10.00
11.00	01100	CAFETERIA	0	0	8,596	9,554		11.00
13.00	01300	NURSING ADMINISTRATION	0	358	0	177	118,300	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	520	0	47	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	557	0	494	0	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	100	0	1	0	16.01
17.00	01700	SOCIAL SERVICE	0	153	0	100	2,086	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,379	9,199	7,850	2,399	49,901	30.00
44.00	04400	SKILLED NURSING FACILITY	7,716	8,492	28,841	2,096	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	80	1,383	0	65	1,350	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	353	1,233	0	459	0	54.00
60.00	06000	LABORATORY	0	1,406	0	591	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	227	1,449	0	336	6,993	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	495	0	202	4,192	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	3	58	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	406	0	175	3,638	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	246	3,487	0	1,002	20,834	88.00
91.00	09100	EMERGENCY	1,432	1,251	0	1,130	23,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	131	0	0	276	5,745	95.00
99.00	09900	CMHC	0	0	0	0	0	99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,564	30,654	45,287	9,554	118,300	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	25	0	0	194.02
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)	83,256	296,518	441,852	98,495	191,272	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.349268	9.673061	9.751324	10.309295	1.616839	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	11,493	6,039	16,071	8,059	7,560	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.738435	0.197005	0.354674	0.843521	0.063905	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 10/27/2014 9:36 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (# OF LOADS)	MEDICAL RECORDS & LIBRARY (NON-NURSIN G HOME CH)	NURSING HOME MEDICAL RECORDS & LIBR (NURSING HO ME CHARGE)	SOCIAL SERVICE (TIME SPENT)		
			14.00	16.00	16.01	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	HOSPITAL BILLING						5.03
5.04	00581	NURSING HOME BILLING						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	894					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,807,308				16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	0	1,737,766			16.01
17.00	01700	SOCIAL SERVICE	0	0	0	446		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4	1,437,895	0	393		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	1,737,766	53		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	566	420,632	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	43,524	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,807,512	0	0		54.00
60.00	06000	LABORATORY	0	1,893,113	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	69,034	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	944,802	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	613,214	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	19,420	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	82,237	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	284,879	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,001	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,394,861	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	259	1,584,074	0	0		88.00
91.00	09100	EMERGENCY	65	648,947	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	543,163	0	0		95.00
99.00	09900	CMHC	0	0	0	0		99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	0		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	894	11,807,308	1,737,766	446		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
194.00	07950	OPTH CLINIC	0	0	0	0		194.00
194.01	07951	RENTAL SPACE	0	0	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.02
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)	79,803	350,707	3,870	105,470		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	89.265101	0.029703	0.002227	236.479821		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	6,975	15,094	870	1,919		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.802013	0.001278	0.000501	4.302691		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-2 | Date/Time Prepared: 10/27/2014 9:36 am

		Description	Worksheet Part	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		IV THERAPY	1	73.00	-15,567	7.00
8.00		IV THERAPY	1	30.00	-17,712	8.00
9.00		IV THERAPY	1	64.00	33,278	9.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 10/27/2014 9:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,393,896		2,393,896	0	2,393,896	30.00
44.00	04400	SKILLED NURSING FACILITY	1,694,496		1,694,496	0	1,694,496	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	361,684		361,684	0	361,684	50.00
53.00	05300	ANESTHESIOLOGY	29,183		29,183	0	29,183	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	677,674		677,674	0	677,674	54.00
60.00	06000	LABORATORY	859,286		859,286	0	859,286	60.00
64.00	06400	INTRAVENOUS THERAPY	33,278		33,278	0	33,278	64.00
65.00	06500	RESPIRATORY THERAPY	31,222	0	31,222	0	31,222	65.00
66.00	06600	PHYSICAL THERAPY	476,055	0	476,055	0	476,055	66.00
67.00	06700	OCCUPATIONAL THERAPY	336,315	0	336,315	0	336,315	67.00
68.00	06800	SPEECH PATHOLOGY	9,205	0	9,205	0	9,205	68.00
69.00	06900	ELECTROCARDIOLOGY	15,078		15,078	0	15,078	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,094		68,094	0	68,094	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,707		43,707	0	43,707	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	536,324		536,324	0	536,324	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,596,458		1,596,458	0	1,596,458	88.00
91.00	09100	EMERGENCY	1,690,698		1,690,698	0	1,690,698	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	108,559		108,559		108,559	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	363,172		363,172	0	363,172	95.00
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,324,384	0	11,324,384	0	11,324,384	200.00
201.00		Less Observation Beds	108,559		108,559		108,559	201.00
202.00		Total (see instructions)	11,215,825	0	11,215,825	0	11,215,825	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 10/27/2014 9:36 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,193,855		1,193,855			30.00
44.00	04400	SKILLED NURSING FACILITY	1,737,766		1,737,766			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,848	410,323	442,171	0.817973	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,002	42,522	43,524	0.670504	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,126	1,769,386	1,807,512	0.374921	0.000000	54.00
60.00	06000	LABORATORY	199,904	1,693,209	1,893,113	0.453901	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	138,531	273,477	412,008	0.080770	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	49,765	19,270	69,035	0.452263	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	549,938	394,864	944,802	0.503867	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	431,700	181,514	613,214	0.548446	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,483	4,937	19,420	0.473996	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	4,933	77,304	82,237	0.183348	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	172,848	112,032	284,880	0.239027	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	90,577	90,577	0.482540	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	673,915	308,938	982,853	0.545681	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	237,433	1,346,641	1,584,074			88.00
91.00	09100	EMERGENCY	0	648,947	648,947	2.605294	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	244,040	244,040	0.444841	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	543,163	543,163	0.668624	0.000000	95.00
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,476,047	8,161,144	13,637,191			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,476,047	8,161,144	13,637,191			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 10/27/2014 9:36 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
44.00	04400	SKILLED NURSING FACILITY			44.00
		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
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.00	09900	CMHC			99.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 10/27/2014 9:36 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,393,896		2,393,896	0	2,393,896	30.00
44.00	04400	SKILLED NURSING FACILITY	1,694,496		1,694,496	0	1,694,496	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	361,684		361,684	0	361,684	50.00
53.00	05300	ANESTHESIOLOGY	29,183		29,183	0	29,183	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	677,674		677,674	0	677,674	54.00
60.00	06000	LABORATORY	859,286		859,286	0	859,286	60.00
64.00	06400	INTRAVENOUS THERAPY	33,278		33,278	0	33,278	64.00
65.00	06500	RESPIRATORY THERAPY	31,222	0	31,222	0	31,222	65.00
66.00	06600	PHYSICAL THERAPY	476,055	0	476,055	0	476,055	66.00
67.00	06700	OCCUPATIONAL THERAPY	336,315	0	336,315	0	336,315	67.00
68.00	06800	SPEECH PATHOLOGY	9,205	0	9,205	0	9,205	68.00
69.00	06900	ELECTROCARDIOLOGY	15,078		15,078	0	15,078	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,094		68,094	0	68,094	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,707		43,707	0	43,707	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	536,324		536,324	0	536,324	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,596,458		1,596,458	0	1,596,458	88.00
91.00	09100	EMERGENCY	1,690,698		1,690,698	0	1,690,698	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	108,559		108,559		108,559	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	363,172		363,172	0	363,172	95.00
99.00	09900	CMHC	0		0		0	99.00
101.00	10100	HOME HEALTH AGENCY	0		0		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	11,324,384	0	11,324,384	0	11,324,384	200.00
201.00		Less Observation Beds	108,559		108,559		108,559	201.00
202.00		Total (see instructions)	11,215,825	0	11,215,825	0	11,215,825	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 10/27/2014 9:36 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,193,855		1,193,855			30.00
44.00	04400	SKILLED NURSING FACILITY	1,737,766		1,737,766			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,848	410,323	442,171	0.817973	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,002	42,522	43,524	0.670504	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	38,126	1,769,386	1,807,512	0.374921	0.000000	54.00
60.00	06000	LABORATORY	199,904	1,693,209	1,893,113	0.453901	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	138,531	273,477	412,008	0.080770	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	49,765	19,270	69,035	0.452263	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	549,938	394,864	944,802	0.503867	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	431,700	181,514	613,214	0.548446	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	14,483	4,937	19,420	0.473996	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	4,933	77,304	82,237	0.183348	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	172,848	112,032	284,880	0.239027	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	90,577	90,577	0.482540	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	673,915	308,938	982,853	0.545681	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	237,433	1,346,641	1,584,074	1.007818	0.000000	88.00
91.00	09100	EMERGENCY	0	648,947	648,947	2.605294	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	244,040	244,040	0.444841	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	543,163	543,163	0.668624	0.000000	95.00
99.00	09900	CMHC	0	0	0			99.00
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,476,047	8,161,144	13,637,191			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,476,047	8,161,144	13,637,191			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 10/27/2014 9:36 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		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
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.00	09900	CMHC			99.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 10/27/2014 9:36 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	160,765	442,171	0.363581	17,194	6,251	50.00
53.00	05300	ANESTHESIOLOGY	212	43,524	0.004871	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	113,450	1,807,512	0.062766	6,080	382	54.00
60.00	06000	LABORATORY	35,316	1,893,113	0.018655	43,826	818	60.00
64.00	06400	INTRAVENOUS THERAPY	0	412,008	0.000000	1,028	0	64.00
65.00	06500	RESPIRATORY THERAPY	23,952	69,035	0.346954	6,553	2,274	65.00
66.00	06600	PHYSICAL THERAPY	17,900	944,802	0.018946	2,279	43	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,023	613,214	0.011453	1,423	16	67.00
68.00	06800	SPEECH PATHOLOGY	75	19,420	0.003862	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,611	82,237	0.043910	1,560	68	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,184	284,880	0.004156	12,377	51	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	188	90,577	0.002076	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,608	982,853	0.021985	53,386	1,174	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	80,552	1,584,074	0.050851	0	0	88.00
91.00	09100	EMERGENCY	36,778	648,947	0.056673	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	82,558	244,040	0.338297	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	585,172	10,162,407		145,706	11,077	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 10/27/2014 9:36 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	0	0	0	0	0	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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 10/27/2014 9:36 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	442,171	0.000000	0.000000	17,194	50.00
53.00	05300	ANESTHESIOLOGY	0	43,524	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,807,512	0.000000	0.000000	6,080	54.00
60.00	06000	LABORATORY	0	1,893,113	0.000000	0.000000	43,826	60.00
64.00	06400	INTRAVENOUS THERAPY	0	412,008	0.000000	0.000000	1,028	64.00
65.00	06500	RESPIRATORY THERAPY	0	69,035	0.000000	0.000000	6,553	65.00
66.00	06600	PHYSICAL THERAPY	0	944,802	0.000000	0.000000	2,279	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	613,214	0.000000	0.000000	1,423	67.00
68.00	06800	SPEECH PATHOLOGY	0	19,420	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	82,237	0.000000	0.000000	1,560	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	284,880	0.000000	0.000000	12,377	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	90,577	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	982,853	0.000000	0.000000	53,386	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,584,074	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	648,947	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	244,040	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	10,162,407			145,706	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 10/27/2014 9:36 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	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 10/27/2014 9:36 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	0.817973	0	292,831	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.670504	0	22,834	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.374921	0	455,583	0	0	54.00
60.00	06000	LABORATORY	0.453901	0	555,226	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.080770	0	86,091	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.452263	0	12,134	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.503867	0	193,004	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.548446	0	93,734	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.473996	0	4,678	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.183348	0	34,881	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.239027	0	107,828	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.482540	0	21,539	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.545681	0	192,023	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	2.605294	0	206,714	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.444841	0	110,401	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.668624		0			95.00
200.00		Subtotal (see instructions)		0	2,389,501	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	2,389,501	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 10/27/2014 9:36 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	239,528	0	50.00
53.00	05300	ANESTHESIOLOGY	15,310	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	170,808	0	54.00
60.00	06000	LABORATORY	252,018	0	60.00
64.00	06400	INTRAVENOUS THERAPY	6,954	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,488	0	65.00
66.00	06600	PHYSICAL THERAPY	97,248	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	51,408	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,217	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,395	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,774	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,393	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	104,783	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	538,551	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	49,111	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	1,575,986	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	1,575,986	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141329 | Component CCN: 14Z329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 10/27/2014 9:36 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	0.817973	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.670504	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.374921	0	0	0	0	54.00
60.00	06000	LABORATORY	0.453901	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.080770	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.452263	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.503867	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.548446	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.473996	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.183348	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.239027	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.482540	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.545681	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	2.605294	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.444841	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.668624		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: 141329 | Component CCN: 14Z329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 10/27/2014 9:36 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
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Component CCN: 145274 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 10/27/2014 9:36 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	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
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Component CCN: 145274 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 10/27/2014 9:36 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	442,171	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	43,524	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,807,512	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	1,893,113	0.000000	0.000000	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	412,008	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	69,035	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	944,802	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	613,214	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	19,420	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	82,237	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	284,880	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	90,577	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	982,853	0.000000	0.000000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,584,074	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	648,947	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	244,040	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	10,162,407			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Component CCN: 145274 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 10/27/2014 9:36 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 10/27/2014 9:36 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,669	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	233	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)	125	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,053	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)	1,052	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	166	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)	165	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	83	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)	904	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)	931	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	132.03	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.03	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,393,896	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)	21,917	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)	21,785	25.00
26.00	Total swing-bed cost (see instructions)	2,159,690	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	234,206	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)	234,206	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)	1,005.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	83,433	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)	83,433	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 10/27/2014 9:36 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						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)	73,588	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	157,021	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)	908,719	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	935,860	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,844,579	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)	108	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,005.18	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	108,559	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 10/27/2014 9:36 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	178,111	234,206	0.760489	108,559	82,558	90.00
91.00	Nursing School cost	0	234,206	0.000000	108,559	0	91.00
92.00	Allied health cost	0	234,206	0.000000	108,559	0	92.00
93.00	All other Medical Education	0	234,206	0.000000	108,559	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141329 Component CCN: 145274	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 10/27/2014 9:36 am
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,678	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,678	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)	9,678	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,694,496	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,694,496	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)	1,694,496	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141329 | Component CCN: 145274 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 10/27/2014 9:36 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		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)	1,694,496	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	175.09	71.00
72.00	Program routine service cost (line 9 x line 71)	0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	0	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1

Component CCN: 145274 | Date/Time Prepared: 10/27/2014 9:36 am

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	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: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 10/27/2014 9:36 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		83,099		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.817973	17,194	14,064	50.00
53.00	05300	ANESTHESIOLOGY	0.670504	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.374921	6,080	2,280	54.00
60.00	06000	LABORATORY	0.453901	43,826	19,893	60.00
64.00	06400	INTRAVENOUS THERAPY	0.080770	1,028	83	64.00
65.00	06500	RESPIRATORY THERAPY	0.452263	6,553	2,964	65.00
66.00	06600	PHYSICAL THERAPY	0.503867	2,279	1,148	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.548446	1,423	780	67.00
68.00	06800	SPEECH PATHOLOGY	0.473996	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.183348	1,560	286	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.239027	12,377	2,958	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.482540	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.545681	53,386	29,132	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	2.605294	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.444841	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		145,706	73,588	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)		145,706		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141329 | Component CCN: 14Z329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 10/27/2014 9:36 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		830,875		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.817973	9,179	7,508	50.00
53.00	05300	ANESTHESIOLOGY	0.670504	1,002	672	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.374921	22,524	8,445	54.00
60.00	06000	LABORATORY	0.453901	130,425	59,200	60.00
64.00	06400	INTRAVENOUS THERAPY	0.080770	134,068	10,829	64.00
65.00	06500	RESPIRATORY THERAPY	0.452263	35,945	16,257	65.00
66.00	06600	PHYSICAL THERAPY	0.503867	455,385	229,453	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.548446	352,036	193,073	67.00
68.00	06800	SPEECH PATHOLOGY	0.473996	12,541	5,944	68.00
69.00	06900	ELECTROCARDIOLOGY	0.183348	3,294	604	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.239027	120,741	28,860	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.482540	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.545681	412,925	225,325	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	2.605294	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.444841	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,690,065	786,170	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,690,065		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141329	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 10/27/2014 9:36 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,575,986	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,575,986	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	1,591,746	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	5,363	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	370,195	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,216,188	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,216,188	30.00
31.00	Primary payer payments	334	31.00
32.00	Subtotal (line 30 minus line 31)	1,215,854	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	43,066	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	37,898	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	38,695	36.00
37.00	Subtotal (see instructions)	1,253,752	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00		0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,253,752	40.00
40.01	Sequestration adjustment (see instructions)	25,075	40.01
41.00	Interim payments	1,084,282	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	144,395	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 10/27/2014 9:36 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		116,552		1,143,778	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0	12/30/2013	5,519	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	12/30/2013	1,087	06/20/2014	65,015	3.50
3.51		06/20/2014	13,201		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)		-14,288		-59,496	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)		102,264		1,084,282	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		34,434		144,395	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		136,698		1,228,677	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: 141329 | Component CCN: 14Z329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 10/27/2014 9:36 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,727,536		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	12/30/2013	32,403		0	3.50
3.51		06/20/2014	353,498		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)		-385,901		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)		2,341,635		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		195,923		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,537,558		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 - SWING BEDS	Provider CCN: 141329 Component CCN: 14Z329	Period: From 07/01/2013 To 06/30/2014	Worksheet E-2 Date/Time Prepared: 10/27/2014 9:36 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,863,025	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	794,032	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	1,835	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)	2,657,057	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,657,057	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)	2,657,057	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	67,972	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)	2,589,085	0	15.00
16.00		0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
17.00	Allowable bad debts (see instructions)	296	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	260	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	296	0	18.00
19.00	Total (see instructions)	2,589,345	0	19.00
19.01	Sequestration adjustment (see instructions)	51,787	0	19.01
20.00	Interim payments	2,341,635	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	195,923	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141329	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part V Date/Time Prepared: 10/27/2014 9:36 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)		
1.00	Inpatient services	157,021	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	157,021	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	158,591	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	158,591	19.00
20.00	Deductibles (exclude professional component)	22,816	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	135,775	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	135,775	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	4,219	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	3,713	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,119	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	139,488	28.00
29.00		0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	139,488	30.00
30.01	Sequestration adjustment (see instructions)	2,790	30.01
31.00	Interim payments	102,264	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	34,434	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141329 Component CCN: 145274	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VI Date/Time Prepared: 10/27/2014 9:36 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	0	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	0	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	0	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)	0	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14	0	15.00
15.01	Sequestration adjustment (see instructions)	0	15.01
16.00	Interim payments	0	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G | Date/Time Prepared: 10/27/2014 9:36 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	1,205,858	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,932,142	0	0	0	4.00
5.00	Other receivable	991,085	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	212,207	0	0	0	7.00
8.00	Prepaid expenses	124,637	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,465,929	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	21,657	0	0	0	12.00
13.00	Land improvements	362,300	0	0	0	13.00
14.00	Accumulated depreciation	-259,373	0	0	0	14.00
15.00	Buildings	8,304,659	0	0	0	15.00
16.00	Accumulated depreciation	-4,815,064	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	4,413,383	0	0	0	23.00
24.00	Accumulated depreciation	-3,687,541	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)	4,340,021	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	393,965	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	393,965	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	9,199,915	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	320,771	0	0	0	37.00
38.00	Salaries, wages, and fees payable	404,762	0	0	0	38.00
39.00	Payroll taxes payable	95,827	0	0	0	39.00
40.00	Notes and loans payable (short term)	203,104	0	0	0	40.00
41.00	Deferred income	495,000	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	260,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,779,464	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,937,872	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	2,937,872	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	4,717,336	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	4,482,579				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)	4,482,579	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	9,199,915	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-1 | Date/Time Prepared: 10/27/2014 9:36 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		4,265,516		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		217,063				2.00
3.00	Total (sum of line 1 and line 2)		4,482,579		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)		4,482,579		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		4,482,579		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-2 Parts I & II | Date/Time Prepared: 10/27/2014 9:36 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	442,968		442,968	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	967,136		967,136	5.00
6.00	Swing bed - NF	64,731		64,731	6.00
7.00	SKILLED NURSING FACILITY	1,737,766		1,737,766	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)	3,212,601		3,212,601	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,212,601		3,212,601	17.00
18.00	Ancillary services	2,260,180	5,626,970	7,887,150	18.00
19.00	Outpatient services	-602	982,798	982,196	19.00
20.00	RURAL HEALTH CLINIC	237,433	1,488,072	1,725,505	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	22.00
23.00	AMBULANCE SERVICES	0	543,163	543,163	23.00
24.00	CMHC		0	0	24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC	0	16,185	16,185	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,709,612	8,657,188	14,366,800	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		11,647,667		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		11,647,667		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141329 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-3 | Date/Time Prepared: 10/27/2014 9:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	14,366,800	1.00
2.00	Less contractual allowances and discounts on patients' accounts	2,907,499	2.00
3.00	Net patient revenues (line 1 minus line 2)	11,459,301	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	11,647,667	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-188,366	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	9,853	6.00
7.00	Income from investments	38,260	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	264,986	24.00
24.01	COUNTY TAX REVENUE	944,554	24.01
24.02	STATE TAX REVENUE	89,076	24.02
24.03	ROUNDING	43	24.03
25.00	Total other income (sum of lines 6-24)	1,346,772	25.00
26.00	Total (line 5 plus line 25)	1,158,406	26.00
27.00	BAD DEBTS	884,989	27.00
27.01	CHARITY CARE	56,354	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	941,343	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	217,063	29.00

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

Provider CCN: 141329 Component CCN: 143981 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 10/27/2014 9:36 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	154,964	0	154,964	0	154,964	1.00
2.00	Physician Assistant	77,434	0	77,434	0	77,434	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	315,370	0	315,370	0	315,370	9.00
10.00	Subtotal (sum of lines 1-9)	547,768	0	547,768	0	547,768	10.00
11.00	Physician Services Under Agreement	0	694,410	694,410	-465,266	229,144	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	112,795	112,795	0	112,795	13.00
14.00	Subtotal (sum of lines 11-13)	0	807,205	807,205	-465,266	341,939	14.00
15.00	Medical Supplies	0	53,834	53,834	0	53,834	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	98,100	98,100	-98,100	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	151,934	151,934	-98,100	53,834	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	547,768	959,139	1,506,907	-563,366	943,541	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	24,685	24,685	0	24,685	29.00
30.00	Administrative Costs	0	44,264	44,264	0	44,264	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	68,949	68,949	0	68,949	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	547,768	1,028,088	1,575,856	-563,366	1,012,490	32.00

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

Provider CCN: 141329 Component CCN: 143981 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 10/27/2014 9:36 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	154,964		1.00
2.00	Physician Assistant	-20,573	56,861		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	315,370		9.00
10.00	Subtotal (sum of lines 1-9)	-20,573	527,195		10.00
11.00	Physician Services Under Agreement	0	229,144		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	112,795		13.00
14.00	Subtotal (sum of lines 11-13)	0	341,939		14.00
15.00	Medical Supplies	0	53,834		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 15-20)	0	53,834		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-20,573	922,968		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	24,685		29.00
30.00	Administrative Costs	-26,900	17,364		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-26,900	42,049		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-47,473	965,017		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141329 Component CCN: 143981 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-2 Date/Time Prepared: 10/27/2014 9:36 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	1.71	7,215	4,200	7,182		1.00
2.00	Physician Assistant	1.12	4,839	2,100	2,352		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1-3)	2.83	12,054		9,534	12,054	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.83	12,054			12,054	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					922,968	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					922,968	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					42,049	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					631,441	15.00
16.00	Total overhead (sum of lines 14 and 15)					673,490	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					673,490	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					673,490	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,596,458	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-3 | Date/Time Prepared: 10/27/2014 9:36 am

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,596,458	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		8,624	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,587,834	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		12,054	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		12,054	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		131.73	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	131.73	131.73	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,270	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	167,297	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	1	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	132	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	132	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) *		167,429	16.00
16.01	Total program charges (see instructions)(from contractor's records)		167,408	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		312	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		312	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.)		121,434	16.04
16.05	Total program cost (see instructions)		121,746	16.05
17.00	Primary payer amounts		102	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		15,324	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		30,396	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		121,644	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,182	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		122,826	22.00
23.00	Allowable bad debts (see instructions)		17,232	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		15,164	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		16,620	24.00
25.00			0	25.00
26.00	Net reimbursable amount (see instructions)		137,990	26.00
26.01	Sequestration adjustment (see instructions)		2,760	26.01
27.00	Interim payments		141,413	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		-6,183	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-4 | Date/Time Prepared: 10/27/2014 9:36 am

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	527,195	527,195	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000506	0.001472	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	267	776	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,544	1,399	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,811	2,175	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	922,968	922,968	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	673,490	673,490	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003046	0.002357	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,051	1,587	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	4,862	3,762	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	43	125	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	113.07	30.10	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	7	13	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	791	391	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		8,624	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		1,182	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141329 Component CCN: 143981	Period: From 07/01/2013 To 06/30/2014	Worksheet M-5 Date/Time Prepared: 10/27/2014 9:36 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		122,646	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		12/30/2013	7,956	3.01
3.02		06/20/2014	10,811	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		18,767	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		141,413	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		6,183	6.02
7.00	Total Medicare program liability (see instructions)		135,230	7.00

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