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: 141349	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/1/2014 10:49 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/1/2014 Time: 10:49 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SPARTA COMMUNITY HOSPITAL (141349) 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	-96	113,140	1	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	18,243	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		242,088		0	10.00
200.00	Total	0	18,147	355,228	1	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 10/30/2014 8:52 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 818 EAST BROADWAY	PO Box:			1.00
2.00	City: SPARTA	State: IL	Zip Code: 62286	County: RANDOLPH	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	SPARTA COMMUNITY HOSPITAL	141349	99914	1	11/01/2005	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SPARTA COMMUNITY SWING BED	14Z349	99914		11/01/2005	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SPARTA COMMUNITY HHA	147694	99914		08/07/1998	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	WOMEN'S HEALTH CLINIC NORTH CAMPUS	143464	99914		10/06/2004	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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.	3	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 10/30/2014 8:52 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.	N			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: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 10/30/2014 8:52 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)	N	N	0.00	0.00	0.000000	65.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 10/30/2014 8:52 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	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)	N	N	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	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF\MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 10/30/2014 8:52 am

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

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	Y	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:	494,168	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.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	1	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2013	06/30/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 10/30/2014 8:52 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	N	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	09/02/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 10/30/2014 8:52 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				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.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-231-5544	STLOUISHEALTHCARE@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 10/30/2014 8:52 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)	09/02/2014			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGING DIRECTOR		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: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 10/30/2014 8:52 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	39,960.00	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	39,960.00	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	39,960.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (Consolidated)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 10/30/2014 8:52 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)	989	167	1,662			1.00
2.00	HMO and other (see instructions)	13	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	824	0	850			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	55			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,813	167	2,567			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)	1,813	167	2,567	0.00	181.39	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	5,056	0	7,105	0.00	9.67	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (Consolidated)	10,572	0	40,781	0.00	54.56	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	245.62	27.00
28.00	Observation Bed Days		63	469			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			6			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: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 10/30/2014 8:52 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	333	68	597	1.00
2.00	HMO and other (see instructions)			4			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	333	68	597	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (Consolidated)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-4

Component CCN: 147694 | Date/Time Prepared: 10/30/2014 8:52 am

Home Health Agency I | PPS

		1.00	
0.00	County	RANDOLPH	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	244.00	44.00	88.00	376.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		3.30	0.00	3.30	5.00
6.00	Direct Nursing Service		4.14	0.00	4.14	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		2.18	0.04	2.22	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.16	0.16	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.10	0.10	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.02	0.00	0.02	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914			20.00
20.01			41180			20.01

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,413	37	88	7	2,545	21.00
22.00	Skilled Nursing Visit Charges	527,250	8,468	17,010	1,485	554,213	22.00
23.00	Physical Therapy Visits	2,239	0	5	8	2,252	23.00
24.00	Physical Therapy Visit Charges	435,950	0	1,457	1,595	439,002	24.00
25.00	Occupational Therapy Visits	147	0	0	0	147	25.00
26.00	Occupational Therapy Visit Charges	28,910	0	0	0	28,910	26.00
27.00	Speech Pathology Visits	89	0	0	0	89	27.00
28.00	Speech Pathology Visit Charges	21,601	0	0	0	21,601	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	23	0	0	0	23	31.00
32.00	Home Health Aide Visit Charges	3,094	0	0	0	3,094	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,911	37	93	15	5,056	33.00
34.00	Other Charges	22,764	183	591	8	23,546	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,039,569	8,651	19,058	3,088	1,070,366	35.00
36.00	Total Number of Episodes (standard/non outlier)	254		22	1	277	36.00
37.00	Total Number of Outlier Episodes		1		0	1	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

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

Provider CCN: 141349 Component CCN: 143464 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-8 | Date/Time Prepared: 10/30/2014 8:52 am

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			1300 NORTH MARKET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	SPARTA		IL	62286	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	09:00	14:00	08:00	19:00	08:30	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			Y	6	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	WOMENS HEALTH CLINIC	143464	14.00
14.01		COULTERVILLE MEDICAL CLINIC	143465	14.01
14.02		FAMILY HEALTH CLINIC	143466	14.02
14.03		STEELEVILLE CLINIC	143467	14.03
14.04		MARISSA MEDICAL CLINIC	143490	14.04
14.05		SPARTA MEDICAL OFFICE	143489	14.05

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

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

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

Provider CCN: 141349
Component CCN: 143464

Period:
From 07/01/2013
To 06/30/2014

Worksheet S-8

Date/Time Prepared:
10/30/2014 8:52 am

Rural Health Clinic (RHC) I

Cost

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	19:00	08:00	19:00	08:00	19:00	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	19:00	09:00	14:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-10 | Date/Time Prepared: 10/30/2014 8:52 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)	0.453773	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,831,364	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	2,302,321	5.00
6.00	Medicaid charges	8,151,828	6.00
7.00	Medicaid cost (line 1 times line 6)	3,699,079	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	112,574	0	112,574	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	51,083	0	51,083	21.00
22.00	Partial payment by patients approved for charity care	4,674	0	4,674	22.00
23.00	Cost of charity care (line 21 minus line 22)	46,409	0	46,409	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)	3,183,272	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	451,097	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,732,175	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,239,787	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,286,196	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,286,196	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 10/30/2014 8:52 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		775,634	775,634	-6,608	769,026	1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG		0	0	212,465	212,465	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		992,179	992,179	23,719	1,015,898	2.00
3.00	00300	OTHER CAP RELATED COST		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,090,685	3,090,685	0	3,090,685	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,168,235	1,980,679	4,148,914	268,040	4,416,954	5.00
6.00	00600	MAINTENANCE & REPAIRS	181,850	12,166	194,016	0	194,016	6.00
7.00	00700	OPERATION OF PLANT	0	450,655	450,655	0	450,655	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,010	44,010	0	44,010	8.00
9.00	00900	HOUSEKEEPING	257,396	57,748	315,144	0	315,144	9.00
10.00	01000	DIETARY	221,377	122,397	343,774	0	343,774	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	87,805	13,692	101,497	0	101,497	13.00
15.00	01500	PHARMACY	0	950,905	950,905	0	950,905	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	153,193	45,271	198,464	0	198,464	16.00
17.00	01700	SOCIAL SERVICE	42,466	672	43,138	0	43,138	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	552,173	552,173	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,056,543	649,474	1,706,017	-18,013	1,688,004	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	534,838	898,285	1,433,123	-462,239	970,884	50.00
53.00	05300	ANESTHESIOLOGY	242,173	356,730	598,903	-565,036	33,867	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	355,980	205,248	561,228	-19,544	541,684	54.00
54.01	05401	ULTRASOUND	99,509	36,184	135,693	619	136,312	54.01
56.00	05600	RADIOISOTOPE	0	392,171	392,171	4,318	396,489	56.00
57.00	05700	CT SCAN	0	96,042	96,042	19,544	115,586	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	291,114	291,114	0	291,114	58.00
60.00	06000	LABORATORY	505,433	852,165	1,357,598	-12,631	1,344,967	60.00
65.00	06500	RESPIRATORY THERAPY	49,350	32,921	82,271	0	82,271	65.00
66.00	06600	PHYSICAL THERAPY	521,576	70,661	592,237	-1,319	590,918	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	22,900	3,706	26,606	7,694	34,300	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	149,064	149,064	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	378,981	378,981	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	107,411	107,411	0	107,411	75.01
75.02	03952	WOUND CENTER	0	117,650	117,650	0	117,650	75.02
76.00	03953	CARDIAC REHAB	77,849	6,084	83,933	0	83,933	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,356,867	1,484,308	4,841,175	-332,427	4,508,748	88.00
91.00	09100	EMERGENCY	686,772	1,075,600	1,762,372	-34,930	1,727,442	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	536,440	142,341	678,781	0	678,781	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		173,308	173,308	-173,308	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,158,552	15,528,096	26,686,648	-9,438	26,677,210	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	747,634	-159,676	587,958	9,438	597,396	194.00
200.00		TOTAL (SUM OF LINES 118-199)	11,906,186	15,368,420	27,274,606	0	27,274,606	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 10/30/2014 8:52 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	-93,591	675,435		1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	212,465		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-142,762	873,136		2.00
3.00	00300	OTHER CAP RELATED COST	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-653,716	2,436,969		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-229,236	4,187,718		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	194,016		6.00
7.00	00700	OPERATION OF PLANT	0	450,655		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	44,010		8.00
9.00	00900	HOUSEKEEPING	0	315,144		9.00
10.00	01000	DIETARY	-43,491	300,283		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	101,497		13.00
15.00	01500	PHARMACY	0	950,905		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-22,154	176,310		16.00
17.00	01700	SOCIAL SERVICE	0	43,138		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-552,173	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-342,825	1,345,179		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	970,884		50.00
53.00	05300	ANESTHESIOLOGY	0	33,867		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	-782	540,902		54.00
54.01	05401	ULTRASOUND	0	136,312		54.01
56.00	05600	RADIOISOTOPE	0	396,489		56.00
57.00	05700	CT SCAN	0	115,586		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	291,114		58.00
60.00	06000	LABORATORY	0	1,344,967		60.00
65.00	06500	RESPIRATORY THERAPY	0	82,271		65.00
66.00	06600	PHYSICAL THERAPY	0	590,918		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	34,300		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	149,064		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	378,981		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	107,411		75.01
75.02	03952	WOUND CENTER	0	117,650		75.02
76.00	03953	CARDIAC REHAB	0	83,933		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	4,508,748		88.00
91.00	09100	EMERGENCY	-2,800	1,724,642		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	678,781		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,083,530	24,593,680		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
194.00	07950	FREESTANDING CLINICS	0	597,396		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-2,083,530	25,191,076		200.00

RECLASSIFICATIONS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 10/30/2014 8:52 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS COST OF SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	149,064	1.00
2.00	IMPLANTABLE DEVICES CHARGED TO PATIENTS	72.00	0	378,981	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	528,045	
	B - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	173,137	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	171	2.00
	TOTALS		0	173,308	
	C - TO RECLASS EKG SALARIES				
1.00	ELECTROCARDIOLOGY	69.00	12,631	0	1.00
	TOTALS		12,631	0	
	D - TO RECLASS PROPERTY INSURANCE				
1.00	OTHER CAP RELATED COST	3.00	0	56,439	1.00
	TOTALS		0	56,439	
	E - TO RECLASS TELEPHONE EXPENSE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	38,214	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	38,214	
	F - TO RECLASS ADMINISTRATIVE EXPENSES				
1.00	ADMINISTRATIVE & GENERAL	5.00	276,435	16,505	1.00
2.00	FREESTANDING CLINICS	194.00	0	303,745	2.00
	TOTALS		276,435	320,250	
	G - TO RECLASS CRNA EXPENSES				
1.00	NONPHYSICIAN ANESTHETISTS	19.00	242,173	310,000	1.00
	TOTALS		242,173	310,000	
	H - TO RECLASS NORTHCAMPUS BLDG				
1.00	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	205,909	1.00
	TOTALS		0	205,909	
	I - TO RECLASS CT SCAN				
1.00	CT SCAN	57.00	19,544	0	1.00
	TOTALS		19,544	0	
	J - TO RECLASS RECRUITMENT EXPENSE				
1.00	RURAL HEALTH CLINIC	88.00	0	6,846	1.00
	TOTALS		0	6,846	
	K - TO RECLASS EKG SALARIES				
1.00	RADIOISOTOPE	56.00	4,318	0	1.00
2.00	ULTRASOUND	54.01	619	0	2.00
	TOTALS		4,937	0	
500.00	Grand Total: Increases		555,720	1,639,011	500.00

RECLASSIFICATIONS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 10/30/2014 8:52 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS COST OF SUPPLIES						
1.00	OPERATING ROOM	50.00	0	462,239	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	18,013	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	12,863	0		3.00
4.00	EMERGENCY	91.00	0	34,930	0		4.00
	TOTALS		0	528,045			
	B - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	173,308	11		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	173,308			
	C - TO RECLASS EKG SALARIES						
1.00	LABORATORY	60.00	12,631	0	0		1.00
	TOTALS		12,631	0			
	D - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	56,439	12		1.00
	TOTALS		0	56,439			
	E - TO RECLASS TELEPHONE EXPENSE						
1.00	PHYSICAL THERAPY	66.00	0	1,319	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	35,528	0		2.00
3.00	FREESTANDING CLINICS	194.00	0	1,367	0		3.00
	TOTALS		0	38,214			
	F - TO RECLASS ADMINISTRATIVE EXPENSES						
1.00	RURAL HEALTH CLINIC	88.00	0	303,745	0		1.00
2.00	FREESTANDING CLINICS	194.00	276,435	16,505	0		2.00
	TOTALS		276,435	320,250			
	G - TO RECLASS CRNA EXPENSES						
1.00	ANESTHESIOLOGY	53.00	242,173	310,000	0		1.00
	TOTALS		242,173	310,000			
	H - TO RECLASS NORTHCAMPUS BLDG						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	205,909	9		1.00
	TOTALS		0	205,909			
	I - TO RECLASS CT SCAN						
1.00	RADIOLOGY - DIAGNOSTIC	54.00	19,544	0	0		1.00
	TOTALS		19,544	0			
	J - TO RECLASS RECRUITMENT EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,846	0		1.00
	TOTALS		0	6,846			
	K - TO RECLASS EKG SALARIES						
1.00	ELECTROCARDIOLOGY	69.00	4,937	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		4,937	0			
500.00	Grand Total: Decreases		555,720	1,639,011			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 10/30/2014 8:52 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	179,834	56,500	0	56,500	0	1.00
2.00	Land Improvements	746,917	0	0	0	0	2.00
3.00	Buildings and Fixtures	15,481,197	197,482	0	197,482	275,000	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	9,902,051	1,163,004	0	1,163,004	176,831	6.00
7.00	HIT designated Assets	433,521	385,911	0	385,911	0	7.00
8.00	Subtotal (sum of lines 1-7)	26,743,520	1,802,897	0	1,802,897	451,831	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	26,743,520	1,802,897	0	1,802,897	451,831	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	236,334	0	1.00
2.00	Land Improvements	746,917	0	2.00
3.00	Buildings and Fixtures	15,403,679	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	10,888,224	0	6.00
7.00	HIT designated Assets	819,432	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,094,586	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	28,094,586	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 10/30/2014 8:52 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	775,634	0	0	0	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	992,179	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,767,813	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	775,634	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	992,179	2.00
3.00	Total (sum of lines 1-2)	0	1,767,813	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 10/30/2014 8:52 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	12,914,519	0	12,914,519	0.463580	26,164	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	3,236,076	0	3,236,076	0.116162	6,556	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	11,707,656	0	11,707,656	0.420258	23,719	2.00
3.00	Total (sum of lines 1-2)	27,858,251	0	27,858,251	1.000000	56,439	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	26,164	569,725	0	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	0	6,556	205,909	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	23,719	849,417	0	2.00
3.00	Total (sum of lines 1-2)	0	0	56,439	1,625,051	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	79,546	26,164	0	0	675,435	1.00
1.01	CAP REL COSTS-NORTH CAMPUS BLDG	0	6,556	0	0	212,465	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	23,719	0	0	873,136	2.00
3.00	Total (sum of lines 1-2)	79,546	56,439	0	0	1,761,036	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 10/30/2014 8:52 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	-93,591	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-NORTH CAMPUS BLDG (chapter 2)		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-94	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-32,383	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-346,407			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	-43,491	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	B	339	ADMINISTRATIVE & GENERAL	5.00	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	-22,154	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
26.01	Depreciation - CAP REL COSTS-NORTH CAMPUS BLDG		0	CAP REL COSTS-NORTH CAMPUS BLDG	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-552,173	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 10/30/2014 8:52 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	
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-142,762	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	BILL COPY CHARGES	B	-8,387	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISCELLANEOUS INCOME	B	-2,738	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	TRANSMED SERVICE REVENUE	B	-3,946	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.04	PERSONAL USE OF AUTO	A	-13,849	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	CRNA BENEFITS	A	-29,959	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.05
33.06	MARKETING SALARY	A	-34,974	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MARKETING EXPENSES	A	-121,282	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MARKETING EMPLOYEE BENEFITS	A	-9,079	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09			0		0.00	0	33.09
33.10	LOBBYING EXPENSES	A	-11,922	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	SELF INSURANCE EXPENSE	A	-556,162	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	SELF INSURANCE EXPENS RHC	A	-58,516	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.12
33.14			0		0.00	0	33.14
33.15			0		0.00	0	33.15
33.16			0		0.00	0	33.16
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,083,530				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: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 10/30/2014 8:52 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	378,825	342,825	36,000	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	18,000	0	18,000	0	0	2.00
3.00	54.00	RADIOLOGY - DIAGNOSTIC	782	782	0	0	0	3.00
4.00	60.00	LABORATORY	21,500	0	21,500	0	0	4.00
5.00	91.00	EMERGENCY	938,754	2,800	935,954	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			1,357,861	346,407	1,011,454		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	2.00
3.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	342,825		1.00
2.00	53.00	ANESTHESIOLOGY	0	0	0	0		2.00
3.00	54.00	RADIOLOGY - DIAGNOSTIC	0	0	0	782		3.00
4.00	60.00	LABORATORY	0	0	0	0		4.00
5.00	91.00	EMERGENCY	0	0	0	2,800		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	346,407		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 10/30/2014 8:52 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					24	1.00
2.00	Line 1 multiplied by 15 hours per week					360	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					38	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	160.25	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.80	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.90	34.90	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					11,185	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					11,185	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					11,185	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					69.80	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					25,128	22.00
23.00	Total salary equivalency (see instructions)					25,128	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					1,326	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					1,326	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					1,326	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					1,287	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 10/30/2014 8:52 am

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.80	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	25,128		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	1,287		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	900		62.00
63.00	Total allowance (sum of lines 57-62)	27,315		63.00
64.00	Total cost of outside supplier services (from your records)	9,615		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	1,326		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	1,326		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	0		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 10/30/2014 8:52 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS NORTH CAMPUS BLDG	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	675,435	675,435				1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	212,465	0	212,465			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	873,136			873,136		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,436,969	0	0	0	2,436,969	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,187,718	64,911	43,024	155,897	504,973	5.00
6.00	00600	MAINTENANCE & REPAIRS	194,016	32,446	0	798	38,108	6.00
7.00	00700	OPERATION OF PLANT	450,655	55,303	5,874	62,830	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	44,010	5,104	0	0	0	8.00
9.00	00900	HOUSEKEEPING	315,144	6,935	0	0	53,940	9.00
10.00	01000	DIETARY	300,283	15,961	0	8,469	46,392	10.00
11.00	01100	CAFETERIA	0	8,872	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	101,497	2,973	0	84	18,400	13.00
15.00	01500	PHARMACY	950,905	4,475	0	2,351	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	176,310	16,097	10,700	5,608	32,103	16.00
17.00	01700	SOCIAL SERVICE	43,138	0	0	225	8,899	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,345,179	64,436	0	57,231	221,408	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	970,884	60,156	0	104,501	112,080	50.00
53.00	05300	ANESTHESIOLOGY	33,867	852	0	588	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	540,902	12,756	0	200,869	70,503	54.00
54.01	05401	ULTRASOUND	136,312	3,477	0	6,562	20,983	54.01
56.00	05600	RADIOISOTOPE	396,489	2,789	0	0	905	56.00
57.00	05700	CT SCAN	115,586	3,506	0	56,811	4,096	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	291,114	0	0	0	0	58.00
60.00	06000	LABORATORY	1,344,967	17,424	0	40,101	103,271	60.00
65.00	06500	RESPIRATORY THERAPY	82,271	2,140	0	5,383	10,342	65.00
66.00	06600	PHYSICAL THERAPY	590,918	4,659	88,746	19,569	109,301	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	34,300	1,685	0	175	6,411	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	149,064	5,530	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	378,981	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	107,411	5,501	0	1,232	0	75.01
75.02	03952	WOUND CENTER	117,650	14,383	0	0	0	75.02
76.00	03953	CARDIAC REHAB	83,933	8,707	0	8,452	16,314	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,508,748	136,370	64,121	73,060	703,461	88.00
91.00	09100	EMERGENCY	1,724,642	28,882	0	39,436	143,919	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	678,781	15,894	0	2,588	112,416	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,593,680	602,224	212,465	852,820	2,338,225	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,937	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	597,396	71,274	0	20,316	98,744	194.00
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)	25,191,076	675,435	212,465	873,136	2,436,969	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 10/30/2014 8:52 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4A	5.00	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,956,523	4,956,523				5.00
6.00	00600	MAINTENANCE & REPAIRS	265,368	65,003	330,371			6.00
7.00	00700	OPERATION OF PLANT	574,662	140,765	30,222	745,649		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	49,114	12,031	2,789	13,837	77,771	8.00
9.00	00900	HOUSEKEEPING	376,019	92,107	3,790	18,800	0	9.00
10.00	01000	DIETARY	371,105	90,903	8,723	43,272	102	10.00
11.00	01100	CAFETERIA	8,872	2,173	4,848	24,051	0	11.00
13.00	01300	NURSING ADMINISTRATION	122,954	30,118	1,625	8,061	0	13.00
15.00	01500	PHARMACY	957,731	234,599	2,445	12,131	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	240,818	58,989	8,797	43,639	0	16.00
17.00	01700	SOCIAL SERVICE	52,262	12,802	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,688,254	413,543	35,213	174,688	25,242	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,247,621	305,609	32,874	163,083	12,608	50.00
53.00	05300	ANESTHESIOLOGY	35,307	8,649	466	2,311	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	825,030	202,094	6,568	32,585	11,696	54.00
54.01	05401	ULTRASOUND	167,334	40,989	1,900	9,426	3,026	54.01
56.00	05600	RADIOISOTOPE	400,183	98,026	1,524	7,562	536	56.00
57.00	05700	CT SCAN	179,999	44,091	1,916	9,505	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	291,114	71,309	0	0	0	58.00
60.00	06000	LABORATORY	1,505,763	368,841	9,522	47,237	0	60.00
65.00	06500	RESPIRATORY THERAPY	100,136	24,529	969	4,805	0	65.00
66.00	06600	PHYSICAL THERAPY	813,193	199,194	2,546	12,630	7,865	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	42,571	10,428	921	4,569	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	154,594	37,868	3,022	14,993	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	378,981	92,833	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	114,144	27,960	3,006	14,914	0	75.01
75.02	03952	WOUND CENTER	132,033	32,342	7,860	0	0	75.02
76.00	03953	CARDIAC REHAB	117,406	28,759	4,758	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,485,760	1,343,761	89,590	0	1,111	88.00
91.00	09100	EMERGENCY	1,936,879	474,444	15,783	78,299	15,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	809,679	198,333	8,685	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,401,409	4,763,092	290,362	740,398	77,771	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,937	474	1,059	5,251	0	190.00
194.00	07950	FREESTANDING CLINICS	787,730	192,957	38,950	0	0	194.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	25,191,076	4,956,523	330,371	745,649	77,771	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 10/30/2014 8:52 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	490,716					9.00
10.00	01000	DIETARY	3,040	517,145				10.00
11.00	01100	CAFETERIA	12,963	366,150	419,057			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	24,212	186,970		13.00
15.00	01500	PHARMACY	3,050	0	21,633	0	1,231,589	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,436	0	57,164	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	11,032	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	108,440	150,995	84,385	93,050	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	74,780	0	33,095	36,734	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	11,802	0	26,934	0	0	54.00
54.01	05401	ULTRASOUND	7,390	0	5,444	0	0	54.01
56.00	05600	RADIOISOTOPE	2,954	0	1,433	0	0	56.00
57.00	05700	CT SCAN	0	0	8,166	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	13,809	0	63,897	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	113	0	8,166	3,872	0	65.00
66.00	06600	PHYSICAL THERAPY	19,636	0	287	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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,231,589	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	4,469	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	19,153	0	2,292	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	129,267	0	10,602	0	0	88.00
91.00	09100	EMERGENCY	49,963	0	47,278	53,314	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	5,000	0	143	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	468,265	517,145	406,163	186,970	1,231,589	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	22,451	0	12,894	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	490,716	517,145	419,057	186,970	1,231,589	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 10/30/2014 8:52 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	411,843					16.00
17.00	01700	SOCIAL SERVICE	0	76,096				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	49,556	76,096	0	2,899,462	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,679	0	0	1,935,083	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	46,733	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	62,209	0	0	1,178,918	0	54.00
54.01	05401	ULTRASOUND	14,129	0	0	249,638	0	54.01
56.00	05600	RADIOISOTOPE	7,802	0	0	520,020	0	56.00
57.00	05700	CT SCAN	17,292	0	0	260,969	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	11,387	0	0	373,810	0	58.00
60.00	06000	LABORATORY	44,073	0	0	2,053,142	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	142,590	0	65.00
66.00	06600	PHYSICAL THERAPY	5,694	0	0	1,061,045	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	58,489	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	210,477	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	471,814	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,231,589	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	2,320	0	0	166,813	0	75.01
75.02	03952	WOUND CENTER	2,741	0	0	174,976	0	75.02
76.00	03953	CARDIAC REHAB	844	0	0	173,212	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	88,991	0	0	7,149,082	0	88.00
91.00	09100	EMERGENCY	61,365	0	0	2,732,910	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,021,840	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	397,082	76,096	0	24,112,612	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	8,721	0	190.00
194.00	07950	FREESTANDING CLINICS	14,761	0	0	1,069,743	0	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	411,843	76,096	0	25,191,076	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 10/30/2014 8:52 am

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	2,899,462		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,935,083		50.00
53.00	05300	ANESTHESIOLOGY	46,733		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,178,918		54.00
54.01	05401	ULTRASOUND	249,638		54.01
56.00	05600	RADIOISOTOPE	520,020		56.00
57.00	05700	CT SCAN	260,969		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	373,810		58.00
60.00	06000	LABORATORY	2,053,142		60.00
65.00	06500	RESPIRATORY THERAPY	142,590		65.00
66.00	06600	PHYSICAL THERAPY	1,061,045		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	58,489		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	210,477		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	471,814		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,231,589		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		75.00
75.01	03951	SLEEP LAB	166,813		75.01
75.02	03952	WOUND CENTER	174,976		75.02
76.00	03953	CARDIAC REHAB	173,212		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	7,149,082		88.00
91.00	09100	EMERGENCY	2,732,910		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	1,021,840		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,112,612		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	8,721		190.00
194.00	07950	FREESTANDING CLINICS	1,069,743		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	25,191,076		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 10/30/2014 8:52 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS NORTH CAMPUS BLDG	CAPITAL RELATED COSTS MVBLE EQUIP	CAPITAL RELATED COSTS Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	85,176	64,911	43,024	155,897	349,008	5.00
6.00	00600	MAINTENANCE & REPAIRS	234	32,446	0	798	33,478	6.00
7.00	00700	OPERATION OF PLANT	0	55,303	5,874	62,830	124,007	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	5,104	0	0	5,104	8.00
9.00	00900	HOUSEKEEPING	0	6,935	0	0	6,935	9.00
10.00	01000	DIETARY	0	15,961	0	8,469	24,430	10.00
11.00	01100	CAFETERIA	0	8,872	0	0	8,872	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,973	0	84	3,057	13.00
15.00	01500	PHARMACY	7,104	4,475	0	2,351	13,930	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,097	10,700	5,608	32,405	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	225	225	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,217	64,436	0	57,231	141,884	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,381	60,156	0	104,501	213,038	50.00
53.00	05300	ANESTHESIOLOGY	0	852	0	588	1,440	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	325	12,756	0	200,869	213,950	54.00
54.01	05401	ULTRASOUND	0	3,477	0	6,562	10,039	54.01
56.00	05600	RADIOISOTOPE	0	2,789	0	0	2,789	56.00
57.00	05700	CT SCAN	58,057	3,506	0	56,811	118,374	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	17,424	0	40,101	57,525	60.00
65.00	06500	RESPIRATORY THERAPY	17,153	2,140	0	5,383	24,676	65.00
66.00	06600	PHYSICAL THERAPY	0	4,659	88,746	19,569	112,974	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	1,685	0	175	1,860	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,530	0	0	5,530	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	5,501	0	1,232	6,733	75.01
75.02	03952	WOUND CENTER	0	14,383	0	0	14,383	75.02
76.00	03953	CARDIAC REHAB	0	8,707	0	8,452	17,159	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,016	136,370	64,121	73,060	287,567	88.00
91.00	09100	EMERGENCY	-6,092	28,882	0	39,436	62,226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	15,894	0	2,588	18,482	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	244,571	602,224	212,465	852,820	1,912,080	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	1,937	0	0	1,937	190.00
194.00	07950	FREESTANDING CLINICS	5,137	71,274	0	20,316	96,727	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	249,708	675,435	212,465	873,136	2,010,744	202.00

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		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	5.00	6.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	349,008				5.00
6.00	00600	MAINTENANCE & REPAIRS	0	4,577	38,055			6.00
7.00	00700	OPERATION OF PLANT	0	9,912	3,481	137,400		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	847	321	2,550	8,822	8.00
9.00	00900	HOUSEKEEPING	0	6,486	437	3,464	0	9.00
10.00	01000	DIETARY	0	6,401	1,005	7,974	12	10.00
11.00	01100	CAFETERIA	0	153	558	4,432	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,121	187	1,485	0	13.00
15.00	01500	PHARMACY	0	16,519	282	2,235	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,154	1,013	8,041	0	16.00
17.00	01700	SOCIAL SERVICE	0	901	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	29,119	4,056	32,192	2,863	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	21,519	3,787	30,051	1,430	50.00
53.00	05300	ANESTHESIOLOGY	0	609	54	426	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	14,230	757	6,004	1,327	54.00
54.01	05401	ULTRASOUND	0	2,886	219	1,737	343	54.01
56.00	05600	RADIOISOTOPE	0	6,902	176	1,393	61	56.00
57.00	05700	CT SCAN	0	3,105	221	1,751	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,021	0	0	0	58.00
60.00	06000	LABORATORY	0	25,971	1,097	8,704	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,727	112	885	0	65.00
66.00	06600	PHYSICAL THERAPY	0	14,026	293	2,327	892	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	734	106	842	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,666	348	2,763	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	6,537	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	1,969	346	2,748	0	75.01
75.02	03952	WOUND CENTER	0	2,277	905	0	0	75.02
76.00	03953	CARDIAC REHAB	0	2,025	548	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	94,622	10,319	0	126	88.00
91.00	09100	EMERGENCY	0	33,407	1,818	14,428	1,768	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	13,965	1,000	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	335,388	33,446	136,432	8,822	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	33	122	968	0	190.00
194.00	07950	FREESTANDING CLINICS	0	13,587	4,487	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	349,008	38,055	137,400	8,822	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 10/30/2014 8:52 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	
			9.00	10.00	11.00	13.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	17,322					9.00
10.00	01000	DIETARY	107	39,929				10.00
11.00	01100	CAFETERIA	458	28,271	42,744			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,470	9,320		13.00
15.00	01500	PHARMACY	108	0	2,207	0	35,281	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	86	0	5,831	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,125	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,828	11,658	8,607	4,638	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,640	0	3,376	1,831	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	417	0	2,747	0	0	54.00
54.01	05401	ULTRASOUND	261	0	555	0	0	54.01
56.00	05600	RADIOISOTOPE	104	0	146	0	0	56.00
57.00	05700	CT SCAN	0	0	833	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	487	0	6,518	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	4	0	833	193	0	65.00
66.00	06600	PHYSICAL THERAPY	693	0	29	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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	35,281	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	158	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	676	0	234	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,562	0	1,081	0	0	88.00
91.00	09100	EMERGENCY	1,764	0	4,822	2,658	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	176	0	15	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,529	39,929	41,429	9,320	35,281	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	793	0	1,315	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	17,322	39,929	42,744	9,320	35,281	202.00

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		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	51,530					16.00
17.00	01700	SOCIAL SERVICE	0	2,251				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,200	2,251		247,296	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,588	0		281,260	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0		2,529	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	7,784	0		247,216	0	54.00
54.01	05401	ULTRASOUND	1,768	0		17,808	0	54.01
56.00	05600	RADIOISOTOPE	976	0		12,547	0	56.00
57.00	05700	CT SCAN	2,164	0		126,448	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,425	0		6,446	0	58.00
60.00	06000	LABORATORY	5,514	0		105,816	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0		28,430	0	65.00
66.00	06600	PHYSICAL THERAPY	712	0		131,946	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		3,542	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		11,307	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		6,537	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		35,281	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	75.00
75.01	03951	SLEEP LAB	290	0		12,244	0	75.01
75.02	03952	WOUND CENTER	343	0		17,908	0	75.02
76.00	03953	CARDIAC REHAB	106	0		20,748	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,135	0		409,412	0	88.00
91.00	09100	EMERGENCY	7,678	0		130,569	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0		33,638	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,683	2,251	0	1,888,928	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		3,060	0	190.00
194.00	07950	FREESTANDING CLINICS	1,847	0		118,756	0	194.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	51,530	2,251	0	2,010,744	0	202.00

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		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	247,296		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	281,260		50.00
53.00	05300	ANESTHESIOLOGY	2,529		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	247,216		54.00
54.01	05401	ULTRASOUND	17,808		54.01
56.00	05600	RADIOISOTOPE	12,547		56.00
57.00	05700	CT SCAN	126,448		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,446		58.00
60.00	06000	LABORATORY	105,816		60.00
65.00	06500	RESPIRATORY THERAPY	28,430		65.00
66.00	06600	PHYSICAL THERAPY	131,946		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
69.00	06900	ELECTROCARDIOLOGY	3,542		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,307		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,537		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,281		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		75.00
75.01	03951	SLEEP LAB	12,244		75.01
75.02	03952	WOUND CENTER	17,908		75.02
76.00	03953	CARDIAC REHAB	20,748		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	409,412		88.00
91.00	09100	EMERGENCY	130,569		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY	33,638		101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,888,928		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	3,060		190.00
194.00	07950	FREESTANDING CLINICS	118,756		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	2,010,744		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 10/30/2014 8:52 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	69,738					1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG	0	27,343				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			849,417			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	11,629,039		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,702	5,537	151,662	2,409,696	-4,956,523	5.00
6.00	00600	MAINTENANCE & REPAIRS	3,350	0	776	181,850	0	6.00
7.00	00700	OPERATION OF PLANT	5,710	756	61,123	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	527	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	716	0	0	257,396	0	9.00
10.00	01000	DIETARY	1,648	0	8,239	221,377	0	10.00
11.00	01100	CAFETERIA	916	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	307	0	82	87,805	0	13.00
15.00	01500	PHARMACY	462	0	2,287	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,662	1,377	5,456	153,193	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	219	42,466	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,653	0	55,676	1,056,543	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,211	0	101,662	534,838	0	50.00
53.00	05300	ANESTHESIOLOGY	88	0	572	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,317	0	195,412	336,436	0	54.00
54.01	05401	ULTRASOUND	359	0	6,384	100,128	0	54.01
56.00	05600	RADIOISOTOPE	288	0	0	4,318	0	56.00
57.00	05700	CT SCAN	362	0	55,268	19,544	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,799	0	39,012	492,802	0	60.00
65.00	06500	RESPIRATORY THERAPY	221	0	5,237	49,350	0	65.00
66.00	06600	PHYSICAL THERAPY	481	11,421	19,037	521,576	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	174	0	170	30,594	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	571	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	568	0	1,199	0	0	75.01
75.02	03952	WOUND CENTER	1,485	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	899	0	8,222	77,849	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,080	8,252	71,075	3,356,867	0	88.00
91.00	09100	EMERGENCY	2,982	0	38,365	686,772	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,641	0	2,518	536,440	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,179	27,343	829,653	11,157,840	-4,956,523	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	200	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	7,359	0	19,764	471,199	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	675,435	212,465	873,136	2,436,969		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.685322	7.770362	1.027924	0.209559		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 10/30/2014 8:52 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	20,234,553					5.00
6.00	00600	MAINTENANCE & REPAIRS	265,368	62,419				6.00
7.00	00700	OPERATION OF PLANT	574,662	5,710	28,398			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	49,114	527	527	14,496		8.00
9.00	00900	HOUSEKEEPING	376,019	716	716	0	152,518	9.00
10.00	01000	DIETARY	371,105	1,648	1,648	19	945	10.00
11.00	01100	CAFETERIA	8,872	916	916	0	4,029	11.00
13.00	01300	NURSING ADMINISTRATION	122,954	307	307	0	0	13.00
15.00	01500	PHARMACY	957,731	462	462	0	948	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	240,818	1,662	1,662	0	757	16.00
17.00	01700	SOCIAL SERVICE	52,262	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,688,254	6,653	6,653	4,705	33,704	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,247,621	6,211	6,211	2,350	23,242	50.00
53.00	05300	ANESTHESIOLOGY	35,307	88	88	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	825,030	1,241	1,241	2,180	3,668	54.00
54.01	05401	ULTRASOUND	167,334	359	359	564	2,297	54.01
56.00	05600	RADIOISOTOPE	400,183	288	288	100	918	56.00
57.00	05700	CT SCAN	179,999	362	362	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	291,114	0	0	0	0	58.00
60.00	06000	LABORATORY	1,505,763	1,799	1,799	0	4,292	60.00
65.00	06500	RESPIRATORY THERAPY	100,136	183	183	0	35	65.00
66.00	06600	PHYSICAL THERAPY	813,193	481	481	1,466	6,103	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	42,571	174	174	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	154,594	571	571	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	378,981	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	114,144	568	568	0	1,389	75.01
75.02	03952	WOUND CENTER	132,033	1,485	0	0	0	75.02
76.00	03953	CARDIAC REHAB	117,406	899	0	0	5,953	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,485,760	16,927	0	207	40,177	88.00
91.00	09100	EMERGENCY	1,936,879	2,982	2,982	2,905	15,529	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	809,679	1,641	0	0	1,554	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,444,886	54,860	28,198	14,496	145,540	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	1,937	200	200	0	0	190.00
194.00	07950	FREESTANDING CLINICS	787,730	7,359	0	0	6,978	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,956,523	330,371	745,649	77,771	490,716	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.244953	5.292795	26.257096	5.364997	3.217430	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	349,008	38,055	137,400	8,822	17,322	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.017248	0.609670	4.838369	0.608582	0.113573	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 10/30/2014 8:52 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	31,451					10.00
11.00	01100	CAFETERIA	22,268	2,925				11.00
13.00	01300	NURSING ADMINISTRATION	0	169	104,240			13.00
15.00	01500	PHARMACY	0	151	0	950,905		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	399	0	0	1,953	16.00
17.00	01700	SOCIAL SERVICE	0	77	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,183	589	51,877	0	235	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	231	20,480	0	136	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	188	0	0	295	54.00
54.01	05401	ULTRASOUND	0	38	0	0	67	54.01
56.00	05600	RADIOISOTOPE	0	10	0	0	37	56.00
57.00	05700	CT SCAN	0	57	0	0	82	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	54	58.00
60.00	06000	LABORATORY	0	446	0	0	209	60.00
65.00	06500	RESPIRATORY THERAPY	0	57	2,159	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2	0	0	27	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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	950,905	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	11	75.01
75.02	03952	WOUND CENTER	0	0	0	0	13	75.02
76.00	03953	CARDIAC REHAB	0	16	0	0	4	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	74	0	0	422	88.00
91.00	09100	EMERGENCY	0	330	29,724	0	291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,451	2,835	104,240	950,905	1,883	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
194.00	07950	FREESTANDING CLINICS	0	90	0	0	70	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	517,145	419,057	186,970	1,231,589	411,843	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.442879	143.267350	1.793649	1.295176	210.877112	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	39,929	42,744	9,320	35,281	51,530	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.269562	14.613333	0.089409	0.037103	26.385049	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 10/30/2014 8:52 am

		Cost Center Description	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			17.00	19.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-NORTH CAMPUS BLDG				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	1,668			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,668			30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	0		75.01
75.02	03952	WOUND CENTER	0	0		75.02
76.00	03953	CARDIAC REHAB	0	0		76.00
		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)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,668	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
194.00	07950	FREESTANDING CLINICS	0	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	76,096	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	45.621103	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	2,251	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.349520	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 10/30/2014 8:52 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	2,899,462		2,899,462	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,935,083		1,935,083	0	0	50.00
53.00	05300	ANESTHESIOLOGY	46,733		46,733	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,178,918		1,178,918	0	0	54.00
54.01	05401	ULTRASOUND	249,638		249,638	0	0	54.01
56.00	05600	RADIOISOTOPE	520,020		520,020	0	0	56.00
57.00	05700	CT SCAN	260,969		260,969	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	373,810		373,810	0	0	58.00
60.00	06000	LABORATORY	2,053,142		2,053,142	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	142,590	0	142,590	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,061,045	0	1,061,045	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	58,489		58,489	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	210,477		210,477	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	471,814		471,814	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,231,589		1,231,589	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	75.00
75.01	03951	SLEEP LAB	166,813		166,813	0	0	75.01
75.02	03952	WOUND CENTER	174,976		174,976	0	0	75.02
76.00	03953	CARDIAC REHAB	173,212		173,212	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,149,082		7,149,082	0	0	88.00
91.00	09100	EMERGENCY	2,732,910		2,732,910	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	455,028		455,028		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,021,840		1,021,840		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,567,640	0	24,567,640	0	0	200.00
201.00		Less Observation Beds	455,028		455,028		0	201.00
202.00		Total (see instructions)	24,112,612	0	24,112,612	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 10/30/2014 8:52 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	1,003,376		1,003,376			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	546,741	3,839,440	4,386,181	0.441177	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	36,526	138,810	175,336	0.266534	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	88,211	2,577,381	2,665,592	0.442272	0.000000	54.00
54.01	05401	ULTRASOUND	185,626	2,493,799	2,679,425	0.093168	0.000000	54.01
56.00	05600	RADIOISOTOPE	75,281	1,568,146	1,643,427	0.316424	0.000000	56.00
57.00	05700	CT SCAN	343,303	7,521,203	7,864,506	0.033183	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	41,581	1,816,402	1,857,983	0.201191	0.000000	58.00
60.00	06000	LABORATORY	677,940	7,921,795	8,599,735	0.238745	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	131,503	186,352	317,855	0.448601	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	565,032	3,809,649	4,374,681	0.242542	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	34,272	378,010	412,282	0.141866	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	200,451	746,213	946,664	0.222335	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	394,851	421,577	816,428	0.577900	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	625,133	1,711,495	2,336,628	0.527080	0.000000	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	75.00
75.01	03951	SLEEP LAB	1,138	572,139	573,277	0.290981	0.000000	75.01
75.02	03952	WOUND CENTER	0	426,614	426,614	0.410151	0.000000	75.02
76.00	03953	CARDIAC REHAB	0	168,316	168,316	1.029088	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,514,086	5,514,086			88.00
91.00	09100	EMERGENCY	120,963	4,462,912	4,583,875	0.596201	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	6,968	258,445	265,413	1.714415	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	1,526,313	1,526,313			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,078,896	48,059,097	53,137,993			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,078,896	48,059,097	53,137,993			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 10/30/2014 8:52 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.000000	54.00
54.01	05401	ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	75.00
75.01	03951	SLEEP LAB	0.000000	75.01
75.02	03952	WOUND CENTER	0.000000	75.02
76.00	03953	CARDIAC REHAB	0.000000	76.00
		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
		OTHER REIMBURSABLE COST CENTERS		
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: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 10/30/2014 8:52 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	281,260	4,386,181	0.064124	292,677	18,768	50.00
53.00	05300	ANESTHESIOLOGY	2,529	175,336	0.014424	21,252	307	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	247,216	2,665,592	0.092743	51,072	4,737	54.00
54.01	05401	ULTRASOUND	17,808	2,679,425	0.006646	100,102	665	54.01
56.00	05600	RADIOISOTOPE	12,547	1,643,427	0.007635	32,963	252	56.00
57.00	05700	CT SCAN	126,448	7,864,506	0.016078	165,670	2,664	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	6,446	1,857,983	0.003469	21,605	75	58.00
60.00	06000	LABORATORY	105,816	8,599,735	0.012305	352,410	4,336	60.00
65.00	06500	RESPIRATORY THERAPY	28,430	317,855	0.089443	67,000	5,993	65.00
66.00	06600	PHYSICAL THERAPY	131,946	4,374,681	0.030161	138,330	4,172	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,542	412,282	0.008591	18,802	162	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,307	946,664	0.011944	103,402	1,235	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	6,537	816,428	0.008007	283,897	2,273	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,281	2,336,628	0.015099	300,435	4,536	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	12,244	573,277	0.021358	1,089	23	75.01
75.02	03952	WOUND CENTER	17,908	426,614	0.041977	0	0	75.02
76.00	03953	CARDIAC REHAB	20,748	168,316	0.123268	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	409,412	5,514,086	0.074248	0	0	88.00
91.00	09100	EMERGENCY	130,569	4,583,875	0.028484	10,710	305	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	54,426	265,413	0.205062	590	121	92.00
200.00		Total (lines 50-199)	1,662,420	50,608,304		1,962,006	50,624	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 10/30/2014 8:52 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
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	0	0	0	0	0	76.00
		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
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: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 10/30/2014 8:52 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	4,386,181	0.000000	0.000000	292,677	50.00
53.00	05300	ANESTHESIOLOGY	0	175,336	0.000000	0.000000	21,252	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	2,665,592	0.000000	0.000000	51,072	54.00
54.01	05401	ULTRASOUND	0	2,679,425	0.000000	0.000000	100,102	54.01
56.00	05600	RADIOISOTOPE	0	1,643,427	0.000000	0.000000	32,963	56.00
57.00	05700	CT SCAN	0	7,864,506	0.000000	0.000000	165,670	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,857,983	0.000000	0.000000	21,605	58.00
60.00	06000	LABORATORY	0	8,599,735	0.000000	0.000000	352,410	60.00
65.00	06500	RESPIRATORY THERAPY	0	317,855	0.000000	0.000000	67,000	65.00
66.00	06600	PHYSICAL THERAPY	0	4,374,681	0.000000	0.000000	138,330	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	412,282	0.000000	0.000000	18,802	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	946,664	0.000000	0.000000	103,402	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	816,428	0.000000	0.000000	283,897	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,336,628	0.000000	0.000000	300,435	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	75.00
75.01	03951	SLEEP LAB	0	573,277	0.000000	0.000000	1,089	75.01
75.02	03952	WOUND CENTER	0	426,614	0.000000	0.000000	0	75.02
76.00	03953	CARDIAC REHAB	0	168,316	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	5,514,086	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	4,583,875	0.000000	0.000000	10,710	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	265,413	0.000000	0.000000	590	92.00
200.00		Total (lines 50-199)	0	50,608,304			1,962,006	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 10/30/2014 8:52 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
54.01	05401	ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		75.00
75.01	03951	SLEEP LAB	0	0	0		75.01
75.02	03952	WOUND CENTER	0	0	0		75.02
76.00	03953	CARDIAC REHAB	0	0	0		76.00
		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
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 10/30/2014 8:52 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	0.441177	0	1,330,440	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.266534	0	39,323	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.442272	0	906,575	0	0	54.00
54.01	05401	ULTRASOUND	0.093168	0	871,993	0	0	54.01
56.00	05600	RADIOISOTOPE	0.316424	0	774,932	0	0	56.00
57.00	05700	CT SCAN	0.033183	0	2,568,013	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.201191	0	560,167	0	0	58.00
60.00	06000	LABORATORY	0.238745	0	3,286,322	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.448601	0	99,822	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.242542	0	1,450,258	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.141866	0	165,920	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.222335	0	217,044	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.577900	0	136,523	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.527080	0	1,160,095	2,302	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0.290981	0	160,333	0	0	75.01
75.02	03952	WOUND CENTER	0.410151	0	241,894	0	0	75.02
76.00	03953	CARDIAC REHAB	1.029088	0	111,249	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.596201	0	796,332	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.714415	0	122,425	0	0	92.00
200.00		Subtotal (see instructions)		0	14,999,660	2,302	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	14,999,660	2,302	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 10/30/2014 8:52 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	586,960	0	50.00
53.00	05300	ANESTHESIOLOGY	10,481	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	400,953	0	54.00
54.01	05401	ULTRASOUND	81,242	0	54.01
56.00	05600	RADIOISOTOPE	245,207	0	56.00
57.00	05700	CT SCAN	85,214	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	112,701	0	58.00
60.00	06000	LABORATORY	784,593	0	60.00
65.00	06500	RESPIRATORY THERAPY	44,780	0	65.00
66.00	06600	PHYSICAL THERAPY	351,748	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	23,538	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,256	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	78,897	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	611,463	1,213	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	75.00
75.01	03951	SLEEP LAB	46,654	0	75.01
75.02	03952	WOUND CENTER	99,213	0	75.02
76.00	03953	CARDIAC REHAB	114,485	0	76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	474,774	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	209,887	0	92.00
200.00		Subtotal (see instructions)	4,411,046	1,213	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,411,046	1,213	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141349 | Component CCN: 14Z349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 10/30/2014 8:52 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	0.441177	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.266534	0	0	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.442272	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.093168	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.316424	0	0	0	0	56.00
57.00	05700	CT SCAN	0.033183	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.201191	0	0	0	0	58.00
60.00	06000	LABORATORY	0.238745	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.448601	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.242542	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.141866	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.222335	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.577900	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.527080	0	0	0	0	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	75.00
75.01	03951	SLEEP LAB	0.290981	0	0	0	0	75.01
75.02	03952	WOUND CENTER	0.410151	0	0	0	0	75.02
76.00	03953	CARDIAC REHAB	1.029088	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.596201	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.714415	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141349 | Component CCN: 14Z349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 10/30/2014 8:52 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
54.01	05401	ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		75.00
75.01	03951	SLEEP LAB	0	0		75.01
75.02	03952	WOUND CENTER	0	0		75.02
76.00	03953	CARDIAC REHAB	0	0		76.00
		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
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 10/30/2014 8:52 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,036	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,131	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)	1,662	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	425	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)	425	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	27	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)	28	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	989	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)	412	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)	412	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)	2,899,462	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)	3,565	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	3,697	25.00
26.00	Total swing-bed cost (see instructions)	831,940	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,067,522	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,067,522	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)	970.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	959,538	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)	959,538	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 10/30/2014 8:52 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)	690,505	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,650,043	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)	399,727	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	399,727	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	799,454	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)	469	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	970.21	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	455,028	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 10/30/2014 8:52 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	247,296	2,067,522	0.119610	455,028	54,426	90.00
91.00	Nursing School cost	0	2,067,522	0.000000	455,028	0	91.00
92.00	Allied health cost	0	2,067,522	0.000000	455,028	0	92.00
93.00	All other Medical Education	0	2,067,522	0.000000	455,028	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 10/30/2014 8:52 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		494,500		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.441177	292,677	129,122	50.00
53.00	05300	ANESTHESIOLOGY	0.266534	21,252	5,664	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.442272	51,072	22,588	54.00
54.01	05401	ULTRASOUND	0.093168	100,102	9,326	54.01
56.00	05600	RADIOISOTOPE	0.316424	32,963	10,430	56.00
57.00	05700	CT SCAN	0.033183	165,670	5,497	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.201191	21,605	4,347	58.00
60.00	06000	LABORATORY	0.238745	352,410	84,136	60.00
65.00	06500	RESPIRATORY THERAPY	0.448601	67,000	30,056	65.00
66.00	06600	PHYSICAL THERAPY	0.242542	138,330	33,551	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.141866	18,802	2,667	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.222335	103,402	22,990	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.577900	283,897	164,064	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.527080	300,435	158,353	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	0.290981	1,089	317	75.01
75.02	03952	WOUND CENTER	0.410151	0	0	75.02
76.00	03953	CARDIAC REHAB	1.029088	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.596201	10,710	6,385	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.714415	590	1,012	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,962,006	690,505	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)		1,962,006		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3

Component CCN: 14Z349 | Date/Time Prepared: 10/30/2014 8:52 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.441177	874	386	50.00
53.00	05300	ANESTHESIOLOGY	0.266534	0	0	53.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.442272	8,818	3,900	54.00
54.01	05401	ULTRASOUND	0.093168	14,009	1,305	54.01
56.00	05600	RADIOISOTOPE	0.316424	2,457	777	56.00
57.00	05700	CT SCAN	0.033183	29,442	977	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.201191	2,140	431	58.00
60.00	06000	LABORATORY	0.238745	85,972	20,525	60.00
65.00	06500	RESPIRATORY THERAPY	0.448601	28,682	12,867	65.00
66.00	06600	PHYSICAL THERAPY	0.242542	328,329	79,634	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.141866	2,856	405	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.222335	16,980	3,775	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.577900	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.527080	151,709	79,963	73.00
75.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	75.00
75.01	03951	SLEEP LAB	0.290981	49	14	75.01
75.02	03952	WOUND CENTER	0.410151	0	0	75.02
76.00	03953	CARDIAC REHAB	1.029088	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.596201	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.714415	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		672,317	204,959	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)		672,317		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141349	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 10/30/2014 8:52 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,412,259	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,412,259	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,456,382	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)	27,804	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,321,076	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,107,502	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,107,502	30.00
31.00	Primary payer payments	239	31.00
32.00	Subtotal (line 30 minus line 31)	2,107,263	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)	422,906	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	372,157	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	297,134	36.00
37.00	Subtotal (see instructions)	2,479,420	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,479,420	40.00
40.01	Sequestration adjustment (see instructions)	49,588	40.01
41.00	Interim payments	2,316,692	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	113,140	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: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I Date/Time Prepared: 10/30/2014 8:52 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		1,302,142		2,309,137	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	01/16/2014	75,546	06/18/2014	7,555	3.01
3.02		06/18/2014	56,367		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		131,913		7,555	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,434,055		2,316,692	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		0		113,140	6.01
6.02	SETTLEMENT TO PROGRAM		96		0	6.02
7.00	Total Medicare program liability (see instructions)		1,433,959		2,429,832	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: 141349 | Component CCN: 14Z349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 10/30/2014 8:52 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		921,825		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	01/18/2014	40,759		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		40,759		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)		962,584		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		18,243		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		980,827		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141349	Period: From 07/01/2013 To 06/30/2014	Worksheet E-1 Part II Date/Time Prepared: 10/30/2014 8:52 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14	597	1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12	989	2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2	13	3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12	1,662	4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200	53,137,993	5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20	112,574	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168	1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	1	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141349 Component CCN: 14Z349	Period: From 07/01/2013 To 06/30/2014	Worksheet E-2 Date/Time Prepared: 10/30/2014 8:52 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)	807,449	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)	207,009	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	824	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,014,458	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,014,458	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,014,458	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	17,492	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)	996,966	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
17.00	Allowable bad debts (see instructions)	5,966	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	3,878	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,000,844	0	19.00
19.01	Sequestration adjustment (see instructions)	20,017	0	19.01
20.00	Interim payments	962,584	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	18,243	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: 141349	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part V Date/Time Prepared: 10/30/2014 8:52 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	1,650,043	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	1,650,043	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,666,543	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)	1,666,543	19.00
20.00	Deductibles (exclude professional component)	254,285	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,412,258	22.00
23.00	Coinsurance	2,091	23.00
24.00	Subtotal (line 22 minus line 23)	1,410,167	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	60,291	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	53,056	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	36,542	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,463,223	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	1,463,223	30.00
30.01	Sequestration adjustment (see instructions)	29,264	30.01
31.00	Interim payments	1,434,055	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	-96	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G | Date/Time Prepared: 10/30/2014 8:52 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	8,223,499	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	4,070,773	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	568,882	0	0	0	7.00
8.00	Prepaid expenses	436,570	0	0	0	8.00
9.00	Other current assets	350,000	0	0	0	9.00
10.00	Due from other funds	200,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	13,849,724	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	236,334	0	0	0	12.00
13.00	Land improvements	746,917	0	0	0	13.00
14.00	Accumulated depreciation	-617,764	0	0	0	14.00
15.00	Buildings	15,403,679	0	0	0	15.00
16.00	Accumulated depreciation	-10,515,604	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	11,707,656	0	0	0	19.00
20.00	Accumulated depreciation	-8,529,534	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	658,465	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	9,090,149	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,272,797	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	30,912	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,303,709	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,243,582	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	550,701	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,038,841	0	0	0	38.00
39.00	Payroll taxes payable	835,954	0	0	0	39.00
40.00	Notes and loans payable (short term)	395,055	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,820,551	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	3,579,256	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	3,579,256	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	6,399,807	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	18,843,775				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)	18,843,775	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,243,582	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-1 | Date/Time Prepared: 10/30/2014 8:52 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		17,915,671		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		928,108				2.00
3.00	Total (sum of line 1 and line 2)		18,843,779		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)		18,843,779		0		11.00
12.00	ROUNDING	4		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)		4		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		18,843,775		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	ROUNDING		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: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 10/30/2014 8:52 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	808,500		808,500	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	119,057		119,057	5.00
6.00	Swing bed - NF	7,704		7,704	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	935,261		935,261	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)	935,261		935,261	17.00
18.00	Ancillary services	3,974,218	36,971,920	40,946,138	18.00
19.00	Outpatient services	199,802	4,766,140	4,965,942	19.00
20.00	RURAL HEALTH CLINIC	0	5,514,086	5,514,086	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,526,313	1,526,313	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	0	943,038	943,038	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,109,281	49,721,497	54,830,778	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,274,606		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)		27,274,606		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-3 | Date/Time Prepared: 10/30/2014 8:52 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	54,830,778	1.00
2.00	Less contractual allowances and discounts on patients' accounts	27,217,454	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,613,324	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,274,606	4.00
5.00	Net income from service to patients (line 3 minus line 4)	338,718	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	264,004	6.00
7.00	Income from investments	110,704	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	43,491	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	22,154	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	14,376	22.00
23.00	Governmental appropriations	245,046	23.00
24.00	OTHER MISCELLANEOUS REVENUES	107,915	24.00
25.00	Total other income (sum of lines 6-24)	807,690	25.00
26.00	Total (line 5 plus line 25)	1,146,408	26.00
27.00	GAIN AND LOSS ON IMPAIRMENT	218,300	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	218,300	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	928,108	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141349 | HHA CCN: 147694 | Period: From 07/01/2013 To 06/30/2014 | Worksheet H | Date/Time Prepared: 10/30/2014 8:52 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	18,855	18,855	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	210,582	0	0	0	89,110	299,692	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	219,561	0	0	0	0	219,561	6.00
7.00	Physical Therapy	105,521	0	0	4,965	0	110,486	7.00
8.00	Occupational Therapy	0	0	0	17,381	0	17,381	8.00
9.00	Speech Pathology	0	0	0	11,970	0	11,970	9.00
10.00	Medical Social Services	0	0	0	60	0	60	10.00
11.00	Home Health Aide	776	0	0	0	0	776	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	536,440	0	0	34,376	107,965	678,781	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	18,855	0	18,855			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	299,692	0	299,692			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	219,561	0	219,561			6.00
7.00	Physical Therapy	0	110,486	0	110,486			7.00
8.00	Occupational Therapy	0	17,381	0	17,381			8.00
9.00	Speech Pathology	0	11,970	0	11,970			9.00
10.00	Medical Social Services	0	60	0	60			10.00
11.00	Home Health Aide	0	776	0	776			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	678,781	0	678,781			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 141349 | HHA CCN: 147694 | Period: From 07/01/2013 To 06/30/2014 | Worksheet H-1 Part I | Date/Time Prepared: 10/30/2014 8:52 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	18,855	0	0	18,855		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	299,692	0	0	18,855	0	318,547	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	219,561	0	0	0	0	219,561	6.00
7.00	Physical Therapy	110,486	0	0	0	0	110,486	7.00
8.00	Occupational Therapy	17,381	0	0	0	0	17,381	8.00
9.00	Speech Pathology	11,970	0	0	0	0	11,970	9.00
10.00	Medical Social Services	60	0	0	0	0	60	10.00
11.00	Home Health Aide	776	0	0	0	0	776	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	678,781	0	0	18,855	0	678,781	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	318,547		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	194,153	413,714	6.00
7.00	Physical Therapy	97,700	208,186	7.00
8.00	Occupational Therapy	15,370	32,751	8.00
9.00	Speech Pathology	10,585	22,555	9.00
10.00	Medical Social Services	53	113	10.00
11.00	Home Health Aide	686	1,462	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		678,781	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 141349 | HHA CCN: 147694 | Period: From 07/01/2013 To 06/30/2014 | Worksheet H-1 Part II | Date/Time Prepared: 10/30/2014 8:52 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	1,641		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	1,641	0	-318,547	360,234	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	219,561	6.00
7.00	Physical Therapy	0	0	0	0	0	110,486	7.00
8.00	Occupational Therapy	0	0	0	0	0	17,381	8.00
9.00	Speech Pathology	0	0	0	0	0	11,970	9.00
10.00	Medical Social Services	0	0	0	0	0	60	10.00
11.00	Home Health Aide	0	0	0	0	0	776	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	1,641	0	-318,547	360,234	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	18,855	0		318,547	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	11.489945	0.000000		0.884278	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141349 | HHA CCN: 147694 | Period: From 07/01/2013 To 06/30/2014 | Worksheet H-2 Part I | Date/Time Prepared: 10/30/2014 8:52 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS NORTH CAMPUS BLDG	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	1.01	2.00	4.00	4A	
1.00	Administrative and General	0	15,894	0	2,588	44,114	62,596	1.00
2.00	Skilled Nursing Care	413,714	0	0	0	46,022	459,736	2.00
3.00	Physical Therapy	208,186	0	0	0	22,089	230,275	3.00
4.00	Occupational Therapy	32,751	0	0	0	0	32,751	4.00
5.00	Speech Pathology	22,555	0	0	0	0	22,555	5.00
6.00	Medical Social Services	113	0	0	0	0	113	6.00
7.00	Home Health Aide	1,462	0	0	0	191	1,653	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	678,781	15,894	0	2,588	112,416	809,679	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.000000	21.00

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	6.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	15,333	8,685	0	0	5,000	0	1.00
2.00	Skilled Nursing Care	112,613	0	0	0	0	0	2.00
3.00	Physical Therapy	56,407	0	0	0	0	0	3.00
4.00	Occupational Therapy	8,022	0	0	0	0	0	4.00
5.00	Speech Pathology	5,525	0	0	0	0	0	5.00
6.00	Medical Social Services	28	0	0	0	0	0	6.00
7.00	Home Health Aide	405	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	198,333	8,685	0	0	5,000	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet H-2 Part I | Date/Time Prepared: 10/30/2014 8:52 am

HHA CCN: 147694 | Home Health Agency I | PPS

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
		11.00	13.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	143	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	143	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		24.00	25.00	26.00	27.00	28.00		
1.00	Administrative and General	91,757	0	91,757				1.00
2.00	Skilled Nursing Care	572,349	0	572,349	56,465	628,814		2.00
3.00	Physical Therapy	286,682	0	286,682	28,283	314,965		3.00
4.00	Occupational Therapy	40,773	0	40,773	4,022	44,795		4.00
5.00	Speech Pathology	28,080	0	28,080	2,770	30,850		5.00
6.00	Medical Social Services	141	0	141	14	155		6.00
7.00	Home Health Aide	2,058	0	2,058	203	2,261		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
20.00	Total (sum of lines 1-19) (2)	1,021,840	0	1,021,840	91,757	1,021,840		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.				0.098655			21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141349 HHA CCN: 147694 | Period: From 07/01/2013 To 06/30/2014 | Worksheet H-2 Part II Date/Time Prepared: 10/30/2014 8:52 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	NORTH CAMPUS BLDG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	1.01	2.00	4.00	5A	5.00	
1.00	Administrative and General	1,641	0	2,518	210,509	0	62,596	1.00
2.00	Skilled Nursing Care	0	0	0	219,610	0	459,736	2.00
3.00	Physical Therapy	0	0	0	105,409	0	230,275	3.00
4.00	Occupational Therapy	0	0	0	0	0	32,751	4.00
5.00	Speech Pathology	0	0	0	0	0	22,555	5.00
6.00	Medical Social Services	0	0	0	0	0	113	6.00
7.00	Home Health Aide	0	0	0	912	0	1,653	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,641	0	2,518	536,440		809,679	20.00
21.00	Total cost to be allocated	15,894	0	2,588	112,416		198,333	21.00
22.00	Unit cost multiplier	9.685558	0.000000	1.027800	0.209559		0.244953	22.00

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	1,641	0	0	1,554	0	1	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,641	0	0	1,554	0	1	20.00
21.00	Total cost to be allocated	8,685	0	0	5,000	0	143	21.00
22.00	Unit cost multiplier	5.292505	0.000000	0.000000	3.217503	0.000000	143.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141349 HHA CCN: 147694

Period: From 07/01/2013 To 06/30/2014

Worksheet H-2 Part II Date/Time Prepared: 10/30/2014 8:52 am

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	Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
		13.00	15.00	16.00	17.00	19.00		
1.00	Administrative and General	0	0	0	0	0		1.00
2.00	Skilled Nursing Care	0	0	0	0	0		2.00
3.00	Physical Therapy	0	0	0	0	0		3.00
4.00	Occupational Therapy	0	0	0	0	0		4.00
5.00	Speech Pathology	0	0	0	0	0		5.00
6.00	Medical Social Services	0	0	0	0	0		6.00
7.00	Home Health Aide	0	0	0	0	0		7.00
8.00	Supplies (see instructions)	0	0	0	0	0		8.00
9.00	Drugs	0	0	0	0	0		9.00
10.00	DME	0	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0	0		13.00
14.00	Clinic	0	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0	0		19.00
20.00	Total (sum of lines 1-19)	0	0	0	0	0		20.00
21.00	Total cost to be allocated	0	0	0	0	0		21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet H-3 Part I | Date/Time Prepared: 10/30/2014 8:52 am

HHA CCN: 147694 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	628,814		628,814	3,682	170.78	1.00
2.00	Physical Therapy	3.00	314,965	0	314,965	3,129	100.66	2.00
3.00	Occupational Therapy	4.00	44,795	0	44,795	144	311.08	3.00
4.00	Speech Pathology	5.00	30,850	0	30,850	125	246.80	4.00
5.00	Medical Social Services	6.00	155		155	2	77.50	5.00
6.00	Home Health Aide	7.00	2,261		2,261	23	98.30	6.00
7.00	Total (sum of lines 1-6)		1,021,840	0	1,021,840	7,105		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	421	1,851			8.00
8.01	Skilled Nursing Care		41180	92	181			8.01
9.00	Physical Therapy		99914	498	1,470			9.00
9.01	Physical Therapy		41180	88	196			9.01
10.00	Occupational Therapy		99914	71	70			10.00
10.01	Occupational Therapy		41180	5	1			10.01
11.00	Speech Pathology		99914	0	72			11.00
11.01	Speech Pathology		41180	17	0			11.01
12.00	Medical Social Services		99914	0	0			12.00
12.01	Medical Social Services		41180	0	0			12.01
13.00	Home Health Aide		99914	0	23			13.00
13.01	Home Health Aide		41180	0	0			13.01
14.00	Total (sum of lines 8-13)			1,192	3,864			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	5,235	5,235	23,546	0.222331	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	513	2,032		87,610	347,025		1.00
2.00	Physical Therapy	586	1,666		58,987	167,700		2.00
3.00	Occupational Therapy	76	71		23,642	22,087		3.00
4.00	Speech Pathology	17	72		4,196	17,770		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	23		0	2,261		6.00
7.00	Total (sum of lines 1-6)	1,192	3,864		174,435	556,843		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141349 | HHA CCN: 147694 | Period: From 07/01/2013 To 06/30/2014 | Worksheet H-3 Part I | Date/Time Prepared: 10/30/2014 8:52 am

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

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	434,635						1.00
2.00	Physical Therapy	226,687						2.00
3.00	Occupational Therapy	45,729						3.00
4.00	Speech Pathology	21,966						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	2,261						6.00
7.00	Total (sum of lines 1-6)	731,278						7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141349 | HHA CCN: 147694 | Period: From 07/01/2013 To 06/30/2014 | Worksheet H-3 Part II | Date/Time Prepared: 10/30/2014 8:52 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.242542	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.000000	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.000000	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.222335	23,546	5,235	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.527080	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141349 | HHA CCN: 147694 | Period: From 07/01/2013 To 06/30/2014 | Worksheet H-4 Part I-II | Date/Time Prepared: 10/30/2014 8:52 am

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	173,189	603,228	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	1,224	7,695	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,552	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	1,806	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	174,413	614,281	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	174,413	614,281	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	174,413	614,281	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	174,413	614,281	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
31.00	Subtotal (line 29 plus/minus line 30)	174,413	614,281	31.00
31.01	Sequestration adjustment (see instructions)	3,488	12,285	31.01
32.00	Interim payments (see instructions)	170,925	601,996	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	35.00

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

Provider CCN: 141349 HHA CCN: 147694 | Period: From 07/01/2013 To 06/30/2014 | Worksheet H-5 | Date/Time Prepared: 10/30/2014 8:52 am

Home Health Agency I | PPS

		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		170,925		601,996	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		170,925		601,996	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		170,925		601,996	7.00

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

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

Provider CCN: 141349 Component CCN: 143464 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 10/30/2014 8:52 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	1,543,498	0	1,543,498	0	1,543,498	1.00
2.00	Physician Assistant	205,743	0	205,743	0	205,743	2.00
3.00	Nurse Practitioner	410,145	0	410,145	0	410,145	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	801,688	0	801,688	0	801,688	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	2,961,074	0	2,961,074	0	2,961,074	10.00
11.00	Physician Services Under Agreement	0	405,141	405,141	0	405,141	11.00
12.00	Physician Supervision Under Agreement	0	1,325	1,325	0	1,325	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	406,466	406,466	0	406,466	14.00
15.00	Medical Supplies	0	316,969	316,969	0	316,969	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	83,787	83,787	0	83,787	18.00
19.00	Other Health Care Costs	0	15,604	15,604	0	15,604	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	416,360	416,360	0	416,360	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,961,074	822,826	3,783,900	0	3,783,900	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	9,179	9,179	0	9,179	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	21,532	21,532	0	21,532	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	30,711	30,711	0	30,711	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	111,828	111,828	0	111,828	29.00
30.00	Administrative Costs	395,792	518,943	914,735	0	914,735	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	395,792	630,771	1,026,563	0	1,026,563	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,356,866	1,484,308	4,841,174	0	4,841,174	32.00

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

Provider CCN: 141349 | Component CCN: 143464 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 10/30/2014 8:52 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	1,543,498		1.00
2.00	Physician Assistant	0	205,743		2.00
3.00	Nurse Practitioner	0	410,145		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	801,688		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	2,961,074		10.00
11.00	Physician Services Under Agreement	0	405,141		11.00
12.00	Physician Supervision Under Agreement	0	1,325		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11-13)	0	406,466		14.00
15.00	Medical Supplies	0	316,969		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	83,787		18.00
19.00	Other Health Care Costs	0	15,604		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	416,360		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	3,783,900		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	9,179		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	21,532		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	30,711		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	111,828		29.00
30.00	Administrative Costs	-332,426	582,309		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-332,426	694,137		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-332,426	4,508,748		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-2

Component CCN: 143464 | Date/Time Prepared: 10/30/2014 8:52 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	6.42	21,625	4,200	26,964		1.00
2.00	Physician Assistant	1.73	5,409	2,100	3,633		2.00
3.00	Nurse Practitioner	4.06	13,747	2,100	8,526		3.00
4.00	Subtotal (sum of lines 1-3)	12.21	40,781		39,123	40,781	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)	12.21	40,781			40,781	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)					3,783,900	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					30,711	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,814,611	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.991949	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					694,137	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,640,334	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,334,471	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					3,334,471	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					3,307,625	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					7,091,525	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141349 | Component CCN: 143464 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-3 | Date/Time Prepared: 10/30/2014 8:52 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)		7,091,525	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		113,594	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		6,977,931	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		40,781	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)		40,781	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		171.11	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)	171.11	171.11	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	5,286	5,286	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	904,487	904,487	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		1,808,974	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,225,398	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		34,430	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		50,827	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,293,138	16.04
16.05	Total program cost (see instructions)		1,343,965	16.05
17.00	Primary payer amounts		191	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		141,724	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		209,849	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,343,774	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		30,640	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,374,414	22.00
23.00	Allowable bad debts (see instructions)		25,007	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		22,006	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		17,043	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		1,396,420	26.00
26.01	Sequestration adjustment (see instructions)		27,928	26.01
27.00	Interim payments		1,126,404	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		242,088	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: 141349 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-4

Component CCN: 143464 | Date/Time Prepared: 10/30/2014 8:52 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)	2,961,074	2,961,074	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000491	0.001657	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,454	4,906	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	31,613	22,409	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	33,067	27,315	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	3,783,900	3,783,900	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	3,334,471	3,334,471	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.008739	0.007219	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	29,140	24,072	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	62,207	51,387	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	501	1,690	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	124.17	30.41	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	91	636	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	11,299	19,341	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)		113,594	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)		30,640	16.00

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

Provider CCN: 141349 Component CCN: 143464 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-5 | Date/Time Prepared: 10/30/2014 8:52 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		1,086,794	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		01/16/2014	28,186	3.01
3.02		06/18/2014	11,424	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)		39,610	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,126,404	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		242,088	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,368,492	7.00

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