

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet S Parts I-III Date/Time Prepared: 8/26/2014 8:38 am
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PART I - COST REPORT STATUS

Provider use only
 1. Electronically filed cost report
 2. Manually submitted cost report
 3. If this is an amended report enter the number of times the provider resubmitted this cost report
 4. Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only
 5. 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. Initial Report for this Provider CCN
 9. Final Report for this Provider CCN
 10. NPR Date:
 11. Contractor's Vendor Code: 4
 12. If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 8/26/2014 Time: 8:38 am

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 KEWANEE HOSPITAL (141325) for the cost reporting period beginning 10/01/2013 and ending 03/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	153,042	-191,072	0	1,207,393	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
4.00 SUBPROVIDER I	0	0	0	0	0	4.00
5.00 Swing bed - SNF	0	79,001	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
9.00 HOME HEALTH AGENCY I	0	0	0	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	7,501	0	0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0	11.00
200.00 Total	0	232,043	-183,571	0	1,207,393	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141325		Period: From 10/01/2013 To 03/31/2014		Worksheet S-2 Part I Date/Time Prepared: 8/26/2014 8:37 am					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1051 WEST SOUTH STREET		PO Box: 747						1.00		
2.00	City: KEWANEE		State: IL		Zip Code: 61443-		County: HENRY		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		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		KEWANEE HOSPITAL	141325	99914	1	07/01/1966	N	0	0	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		KEWANEE SWING BED	14Z325	99914		03/19/2003	N	0	N	7.00
8.00	Swing Beds - NF		KEWANEE SWING BED	14Z325	99914		03/19/2003	N		N	8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA										12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC		FAMILY HEALTH CLINIC	143445	99914		10/01/1998	N	0	N	15.00
16.00	Hospital-Based Health Clinic - FOHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
17.10	Hospital-Based (CORF) I										17.10
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)					10/01/2013	03/31/2014		20.00		
21.00	Type of Control (see instructions)					2				21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N				22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)									22.01	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					0		N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.					0	0	0	0	0	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
						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	

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		Beginning: 1.00	Ending: 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 1.00	Y/N 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 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00	
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N	46.00	
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N	47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00	
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.				58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00	
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 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
61.01	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
		Program Name 1.00		Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 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

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
		1.00				
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.						
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	65.00
			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 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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
					1.00	2.00	
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)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
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

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		V 1.00	XIX 2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		1			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	71,559	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
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

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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:			
142.00	Street:	PO Box:					
143.00	City:	State:		Zip Code:			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.				N	145.00	
				1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N	146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00	
		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	Y	Y	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
161.10	CORF		N	N	N	161.10	
				1.00			
165.00	Multi campus Is this hospital part of a Multi campus 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						
				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)				378,322	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	
				Beginni ng	Endi ng		
				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)				10/01/2013	03/31/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet S-2 Part II Date/Time Prepared: 8/26/2014 8:37 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	Y	03/31/2014		1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	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.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
		Y/N	Legal Oper.		
		1.00	2.00		
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N			
		1.00			
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			Y	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	07/25/2014	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet S-2 Part II Date/Time Prepared: 8/26/2014 8:37 am
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
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 relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	STEVE		THOMPSON	41.00
42.00	Enter the employer/company name of the cost report preparer.	WI PFLI LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	920-662-2820		STHOMPSON@WI PFLI . COM	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	07/25/2014	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PARTNER	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: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet S-3
Part I
Date/Time Prepared:
8/26/2014 8:37 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	4,004	14,040.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		22	4,004	14,040.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	3	546	504.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY					0	13.00
14.00 Total (see instructions)		25	4,550	14,544.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0	0	0	17.00
18.00 SUBPROVIDER	42.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0	0		24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		25			0	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	0		32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet S-3
Part I
Date/Time Prepared:
8/26/2014 8:37 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	376	62	585			1.00
2.00 HMO and other (see instructions)	21	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	168	0	168			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	44			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	544	62	797			7.00
8.00 INTENSIVE CARE UNIT	14	1	21			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	0			13.00
14.00 Total (see instructions)	558	63	818	0.00	170.76	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	0	0	0.00	0.00	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0	0	0	0.00	0.00	24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	722	2,062	5,684	0.00	18.51	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	189.27	27.00
28.00 Observation Bed Days		0	203			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet S-3
Part I
Date/Time Prepared:
8/26/2014 8:37 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
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	153	32	255	1.00
2.00 HMO and other (see instructions)				7			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	153	32	255	14.00	14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY	0.00						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE	0.00						24.00
24.10 HOSPICE (non-distinct part)							24.10
25.00 CMHC - CMHC							25.00
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33.00 LTCH non-covered days							33.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141325 Component CCN: 143445	Period: From 10/01/2013 To 03/31/2014	Worksheet S-8 Date/Time Prepared: 8/26/2014 8:37 am
			Rural Health Clinic (RHC) I	Cost
				1.00
1.00	Clinic Address and Identification Street		1051 WEST SOUTH STREET	1.00
		City	State	Zip Code
2.00	City, State, Zip Code, County	KEWANEE	IL	61443
				1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0
			Grant Award	Date
			1.00	2.00
Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)			4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			6.00
7.00	Appalachian Regional Commission			7.00
8.00	Look-Alikes			8.00
9.00	OTHER (SPECIFY)			9.00
9.01				9.01
9.02				9.02
9.03				9.03
9.04				9.04
9.05				9.05
9.06				9.06
9.07				9.07
9.08				9.08
9.09				9.09
9.10				9.10
				1.00
				2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			0
		Sunday	Monday	Tuesday
		from	to	from
		1.00	2.00	3.00
		4.00	5.00	
11.00	Facility hours of operations (1) Clinic			11.00
				1.00
				2.00
12.00	Have you received an approval for an exception to the productivity standard?			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.			13.00
			Provider name	CCN number
			1.00	2.00
14.00	Provider name, CCN number			14.00
		Y/N	V	XVIII
		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)			15.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141325 Component CCN: 143445		Period: From 10/01/2013 To 03/31/2014		Worksheet S-8 Date/Time Prepared: 8/26/2014 8:37 am	
				Rural Health Clinic (RHC) I		Cost	
		County					
		4.00					
2.00	City, State, Zip Code, County	HENRY				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)							
11.00	Clinic	17:00	09:00	17:00	09:00	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	09:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet S-10 Date/Time Prepared: 8/26/2014 8:37 am
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				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)		0.410452		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		1,094,086		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		1,259,011		5.00
6.00	Medicaid charges		6,570,857		6.00
7.00	Medicaid cost (line 1 times line 6)		2,697,021		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)		343,924		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)		343,924		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	411,861	101,009	512,870	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	169,049	41,459	210,508	21.00
22.00	Partial payment by patients approved for charity care	1,016	1,001	2,017	22.00
23.00	Cost of charity care (line 21 minus line 22)	168,033	40,458	208,491	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		1,850,538		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		387,944		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		1,462,594		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		600,325		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		808,816		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,152,740		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet A
Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,484,908		1,484,908	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		504,026		504,026	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	88,463	1,129,950		1,218,413	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	847,633	1,575,949	-24,633	2,398,949	5.00
7.00	00700	OPERATION OF PLANT	146,529	378,115		524,644	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	62,245		62,245	8.00
9.00	00900	HOUSEKEEPING	105,992	22,431		128,423	9.00
10.00	01000	DIETARY	121,687	78,411	-146,580	53,518	10.00
11.00	01100	CAFETERIA	0	0	146,580	146,580	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	13,557	6,816		20,373	14.00
15.00	01500	PHARMACY	86,541	179,557		266,098	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	65,245	36,612		101,857	16.00
17.00	01700	SOCIAL SERVICE	0	0		0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	801,945	172,231		974,176	30.00
31.00	03100	INTENSIVE CARE UNIT	0	104		28,717	31.00
41.00	04100	SUBPROVIDER - IRF	0	0		0	41.00
42.00	04200	SUBPROVIDER	0	0		0	42.00
43.00	04300	NURSERY	0	0		0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	238,576	418,872		657,448	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		0	52.00
53.00	05300	ANESTHESIOLOGY	138,362	28,250		166,612	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	389,171	671,660		1,060,831	54.00
56.00	05600	RADIOISOTOPE	0	0		121,397	56.00
56.01	05602	ULTRASOUND	0	0		79,155	56.01
57.00	05700	CT SCAN	0	0		147,223	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		270,250	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		0	59.00
60.00	06000	LABORATORY	283,951	464,304		748,255	60.00
60.01	06001	BLOOD LABORATORY	0	0		0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		39,996	62.00
65.00	06500	RESPIRATORY THERAPY	0	0		100,065	65.00
66.00	06600	PHYSICAL THERAPY	333,857	21,095		354,952	66.00
67.00	06700	OCCUPATIONAL THERAPY	95,740	2,539		98,279	67.00
68.00	06800	SPEECH PATHOLOGY	53,713	1,985		55,698	68.00
69.01	06901	CARDIO-PULMONARY	133,217	20,992		154,209	69.01
69.02	06902	VASCULAR LAB	0	0		36,077	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		14,068	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		0	73.00
73.01	07301	ONCOLOGY	0	0		0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	643,640	38,674		682,314	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	89.00
91.00	09100	EMERGENCY	401,944	1,001,476		1,403,420	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		477	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		0	96.00
99.10	09910	CORF	0	0		0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0		0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		0	110.00
111.00	11100	ISLET ACQUISITION	0	0		0	111.00
116.00	11600	HOSPICE	0	0		0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,989,763	8,301,202		13,290,965	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	2,993	17,820		20,813	190.00
190.01	19001	FOUNDATION	10,543	1,788		12,331	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	29,185		29,185	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,007		7,007	192.00
200.00		TOTAL (SUM OF LINES 118-199)	5,003,299	8,357,002		13,360,301	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet A
Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-578,188	906,720	1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	-242,973	261,053	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-202	1,218,211	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-22,912	2,376,037	5.00
7.00	00700 OPERATION OF PLANT	0	524,644	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	62,245	8.00
9.00	00900 HOUSEKEEPING	0	128,423	9.00
10.00	01000 DIETARY	0	53,518	10.00
11.00	01100 CAFETERIA	-63,002	83,578	11.00
13.00	01300 NURSING ADMINISTRATION	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	20,373	14.00
15.00	01500 PHARMACY	0	266,098	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-2,781	99,076	16.00
17.00	01700 SOCIAL SERVICE	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-354,597	616,130	30.00
31.00	03100 INTENSIVE CARE UNIT	0	28,821	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-182,495	534,796	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	-152,209	14,403	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	406,729	54.00
56.00	05600 RADIOISOTOPE	0	121,397	56.00
56.01	05602 ULTRASOUND	0	79,155	56.01
57.00	05700 CT SCAN	0	147,223	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	270,250	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	-11,073	697,186	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	39,996	62.00
65.00	06500 RESPIRATORY THERAPY	0	100,065	65.00
66.00	06600 PHYSICAL THERAPY	-14,461	340,491	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	98,279	67.00
68.00	06800 SPEECH PATHOLOGY	0	55,698	68.00
69.01	06901 CARDIO-PULMONARY	0	54,144	69.01
69.02	06902 VASCULAR LAB	0	36,077	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	14,068	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-4,850	-4,850	73.00
73.01	07301 ONCOLOGY	0	0	73.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	607,291	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
91.00	09100 EMERGENCY	-681,617	722,280	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
99.10	09910 CORF	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	111.00
116.00	11600 HOSPICE	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2,311,360	10,979,605	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	20,813	190.00
190.01	19001 FOUNDATION	0	12,331	190.01
190.02	19002 DURABLE MEDICAL EQUIP-RENTED	0	29,185	190.02
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	7,007	192.00
200.00	TOTAL (SUM OF LINES 118-199)	-2,311,360	11,048,941	200.00

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
C - CAFETERIA						
1.00	CAFETERIA	11.00	89,141	57,439	1.00	
	TOTALS		89,141	57,439		
D - BLOOD COSTS						
1.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	62.00	4,211	35,785	1.00	
	TOTALS		4,211	35,785		
E - RESPIRATORY THERAPY						
1.00	RESPIRATORY THERAPY	65.00	64,208	35,857	1.00	
	TOTALS		64,208	35,857		
G - RADIOLOGY SERVICES						
1.00	RADIOISOTOPE	56.00	0	121,397	1.00	
2.00	CT SCAN	57.00	83,879	63,344	2.00	
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	0	270,250	3.00	
4.00	VASCULAR LAB	69.02	36,077	0	4.00	
5.00	ULTRASOUND	56.01	79,155	0	5.00	
	TOTALS		199,111	454,991		
H - HOSPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,112	1.00	
	TOTALS		0	1,112		
I - CASE MANAGERS/DI R NSG						
1.00	ADULTS & PEDIATRICS	30.00	24,960	0	1.00	
2.00	INTENSIVE CARE UNIT	31.00	308	0	2.00	
3.00	EMERGENCY	91.00	477	0	3.00	
	TOTALS		25,745	0		
J - PROFESSIONAL SALARIES IN RHC						
1.00	OPERATING ROOM	50.00	110,915	0	1.00	
	TOTALS		110,915	0		
K - IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	14,068	1.00	
	TOTALS		0	14,068		
L - ICU EXPENSE RECLASS						
1.00	INTENSIVE CARE UNIT	31.00	20,588	7,821	1.00	
	TOTALS		20,588	7,821		
M - RHC UROLOGY						
1.00	RURAL HEALTH CLINIC	88.00	0	37,004	1.00	
	TOTALS		0	37,004		
500.00	Grand Total: Increases		513,919	644,077	500.00	

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
C - CAFETERIA						
1.00	DIETARY	10.00	89,141	57,439	0	1.00
	TOTALS		89,141	57,439		
D - BLOOD COSTS						
1.00	LABORATORY	60.00	4,211	35,785	0	1.00
	TOTALS		4,211	35,785		
E - RESPIRATORY THERAPY						
1.00	CARDIO-PULMONARY	69.01	64,208	35,857	0	1.00
	TOTALS		64,208	35,857		
G - RADIOLOGY SERVICES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	199,111	454,991	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
	TOTALS		199,111	454,991		
H - HOSPITAL COSTS						
1.00	RURAL HEALTH CLINIC	88.00	0	1,112	0	1.00
	TOTALS		0	1,112		
I - CASE MANAGERS/DI R NSG						
1.00	ADMINISTRATIVE & GENERAL	5.00	25,745	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		25,745	0		
J - PROFESSIONAL SALARIES IN RHC						
1.00	RURAL HEALTH CLINIC	88.00	110,915	0	0	1.00
	TOTALS		110,915	0		
K - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	14,068	0	1.00
	TOTALS		0	14,068		
L - ICU EXPENSE RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	20,588	7,821	0	1.00
	TOTALS		20,588	7,821		
M - RHC UROLOGY						
1.00	OPERATING ROOM	50.00	0	37,004	0	1.00
	TOTALS		0	37,004		
500.00	Grand Total: Decreases		513,919	644,077		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet A-7
Part I
Date/Time Prepared:
8/26/2014 8:37 am

		Acquisitions			Disposals and Retirements		
		Beginning Balances	Purchases	Donation			Total
		1.00	2.00	3.00			4.00
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	1.00	
2.00	Land Improvements	1,894,987	0	0	0	2.00	
3.00	Buildings and Fixtures	19,726,803	19,890	0	19,890	3.00	
4.00	Building Improvements	0	0	0	0	4.00	
5.00	Fixed Equipment	0	0	0	0	5.00	
6.00	Movable Equipment	21,252,479	223,580	0	223,580	6.00	
7.00	HIT designated Assets	2,587,856	378,322	0	378,322	7.00	
8.00	Subtotal (sum of lines 1-7)	45,462,125	621,792	0	621,792	8.00	
9.00	Reconciling Items	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	45,462,125	621,792	0	621,792	10.00	
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0			1.00	
2.00	Land Improvements	1,894,987	0			2.00	
3.00	Buildings and Fixtures	19,746,693	0			3.00	
4.00	Building Improvements	0	0			4.00	
5.00	Fixed Equipment	0	0			5.00	
6.00	Movable Equipment	21,476,059	0			6.00	
7.00	HIT designated Assets	2,966,178	0			7.00	
8.00	Subtotal (sum of lines 1-7)	46,083,917	0			8.00	
9.00	Reconciling Items	0	0			9.00	
10.00	Total (line 8 minus line 9)	46,083,917	0			10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet A-7
Part II
Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,484,908	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	504,026	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,988,934	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,484,908				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	504,026				2.00
3.00	Total (sum of lines 1-2)	0	1,988,934				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet A-7
Part III
Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	21,641,680	0	21,641,680	0.504537	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	21,252,479	0	21,252,479	0.495463	0	2.00
3.00	Total (sum of lines 1-2)	42,894,159	0	42,894,159	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,484,443	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	261,053	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,745,496	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	-577,723	0	0	0	906,720	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	261,053	2.00
3.00	Total (sum of lines 1-2)	-577,723	0	0	0	1,167,773	3.00

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
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-577,723	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,113,171			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	-63,002	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-2,781	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
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		0			0.00	0 32.00
33.00 PROVIDER TAX	A	-370,261		ADMINISTRATIVE & GENERAL	5.00	0 33.00
33.01 PHARMACY SALES	B	-4,850		DRUGS CHARGED TO PATIENTS	73.00	0 33.01
33.08		0			0.00	0 33.08
33.14 MISC PT SALES	B	-14,461		PHYSICAL THERAPY	66.00	0 33.14
33.20 FITNESS FEES	B	-25		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.20
33.23 MEDICAL STAFF FEES	B	-2,375		ADMINISTRATIVE & GENERAL	5.00	0 33.23
33.26 OTHER MISC INCOME	B	-2,196		ADMINISTRATIVE & GENERAL	5.00	0 33.26
34.00 MEDICAL STAFF DUES TRAVELING DR'S	B	-700		ADMINISTRATIVE & GENERAL	5.00	0 34.00
35.00		0			0.00	0 35.00
37.00 OTHER ADJUSTMENTS (SPECIFY)		0			0.00	0 37.00
38.00 PATIENT TELEPHONE COSTS - SALARIES	A	-730		ADMINISTRATIVE & GENERAL	5.00	0 38.00
39.00 PATIENT TELEPHONE COSTS - BENEFITS	A	-177		EMPLOYEE BENEFITS DEPARTMENT	4.00	0 39.00
40.00 PATIENT TELEPHONE COSTS - OTHER	A	-194		ADMINISTRATIVE & GENERAL	5.00	0 40.00
41.00 PATIENT TELEPHONE COSTS - DEPRE	A	-465		NEW CAP REL COSTS-BLDG & FIXT	1.00	9 41.00
42.00 CRNA	A	-152,209		ANESTHESIOLOGY	53.00	0 42.00
43.00 LOBBYING PORTION OF DUES	A	-11,200		ADMINISTRATIVE & GENERAL	5.00	0 43.00
43.02 PROTESTED PROVIDER TAX	A	370,261		ADMINISTRATIVE & GENERAL	5.00	0 43.02
43.04 NON-REIMB EXP- ADMIN	A	-63		ADMINISTRATIVE & GENERAL	5.00	0 43.04
44.00 NON-ALLOWABLE ADVERTISING	A	-5,454		ADMINISTRATIVE & GENERAL	5.00	0 44.00
44.01 EMR EQUIPMENT DEPRECIATION EXPENSE	A	-242,973		NEW CAP REL COSTS-MVBLE EQUIP	2.00	9 44.01
44.02 CONTRACT TERMINATION	A	-50,000		ADULTS & PEDIATRICS	30.00	0 44.02
44.03 PATIENT TRANSPORTATION SERVICES	A	-66,611		EMERGENCY	91.00	0 44.03
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,311,360				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: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet A-8-2

Date/Time Prepared:
8/26/2014 8:37 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	60.00	LABORATORY	11,073	11,073	0	0	0	1.00
2.00	91.00	EMERGENCY	872,648	615,006	191,032	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	30,387	30,387	0	0	0	3.00
4.00	50.00	OPERATING ROOM	110,915	110,915	0	0	0	4.00
5.00	50.00	OPERATING ROOM	57,700	57,700	0	0	0	5.00
6.00	50.00	OPERATING ROOM	7,350	7,350	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	274,210	274,210	0	0	0	7.00
8.00	50.00	OPERATING ROOM	6,530	6,530	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			1,370,813	1,113,171	191,032			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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	7.00
8.00	50.00	OPERATING ROOM	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	60.00	LABORATORY	0	0	0	11,073		1.00
2.00	91.00	EMERGENCY	0	0	0	615,006		2.00
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	30,387		3.00
4.00	50.00	OPERATING ROOM	0	0	0	110,915		4.00
5.00	50.00	OPERATING ROOM	0	0	0	57,700		5.00
6.00	50.00	OPERATING ROOM	0	0	0	7,350		6.00
7.00	30.00	ADULTS & PEDIATRICS	0	0	0	274,210		7.00
8.00	50.00	OPERATING ROOM	0	0	0	6,530		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,113,171		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet B
Part I
Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	906,720	906,720			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	261,053		261,053		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,218,211	4,092	403	1,222,706	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,376,037	143,607	9,731	204,464	2,733,839
7.00 00700	OPERATION OF PLANT	524,644	76,474	4,813	36,453	642,384
8.00 00800	LAUNDRY & LINEN SERVICE	62,245	3,894	0	0	66,139
9.00 00900	HOUSEKEEPING	128,423	7,487	377	26,369	162,656
10.00 01000	DIETARY	53,518	20,845	3,817	8,097	86,277
11.00 01100	CAFETERIA	83,578	7,111	0	22,176	112,865
13.00 01300	NURSING ADMINISTRATION	0	2,709	0	0	2,709
14.00 01400	CENTRAL SERVICES & SUPPLY	20,373	0	4,532	3,373	28,278
15.00 01500	PHARMACY	266,098	12,802	1,965	21,530	302,395
16.00 01600	MEDICAL RECORDS & LIBRARY	99,076	17,712	1,797	16,232	134,817
17.00 01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	616,130	169,833	16,259	200,595	1,002,817
31.00 03100	INTENSIVE CARE UNIT	28,821	24,005	1,796	5,198	59,820
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	534,796	90,160	67,411	86,946	779,313
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	14,403	1,270	15,736	34,422	65,831
54.00 05400	RADIOLOGY-DIAGNOSTIC	406,729	43,580	40,832	47,283	538,424
56.00 05600	RADIO SOTOPE	121,397	2,540	0	0	123,937
56.01 05602	ULTRASOUND	79,155	2,201	9,434	19,692	110,482
57.00 05700	CT SCAN	147,223	3,556	0	20,867	171,646
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	270,250	7,281	0	0	277,531
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	697,186	18,587	16,382	69,593	801,748
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	39,996	1,693	0	1,048	42,737
65.00 06500	RESPIRATORY THERAPY	100,065	5,249	0	15,974	121,288
66.00 06600	PHYSICAL THERAPY	340,491	31,681	8,313	83,057	463,542
67.00 06700	OCCUPATIONAL THERAPY	98,279	2,878	310	23,818	125,285
68.00 06800	SPEECH PATHOLOGY	55,698	1,016	449	13,363	70,526
69.01 06901	CARDIO-PULMONARY	54,144	15,652	24,373	17,168	111,337
69.02 06902	VASCULAR LAB	36,077	1,016	0	8,975	46,068
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	14,068	0	0	0	14,068
73.00 07300	DRUGS CHARGED TO PATIENTS	-4,850	0	0	0	-4,850
73.01 07301	ONCOLOGY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	607,291	88,270	1,246	132,531	829,338
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00 09100	EMERGENCY	722,280	66,437	29,092	100,114	917,923
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
99.10 09910	CORF	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00 11100	ISLET ACQUISITION	0	0	0	0	0
116.00 11600	HOSPICE	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	10,979,605	873,638	259,068	1,219,338	10,941,170
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	20,813	8,607	119	745	30,284
190.01 19001	FOUNDATION	12,331	0	1,598	2,623	16,552
190.02 19002	DURABLE MEDICAL EQUIP-RENTED	29,185	0	9	0	29,194
192.00 19200	PHYSICIANS' PRIVATE OFFICES	7,007	24,475	259	0	31,741
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	11,048,941	906,720	261,053	1,222,706	11,048,941

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet B
Part I
Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,733,839				5.00
7.00	00700	OPERATION OF PLANT	211,080	853,464			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	21,732	4,869	92,740		8.00
9.00	00900	HOUSEKEEPING	53,447	9,362	13,768	239,233	9.00
10.00	01000	DIETARY	28,350	26,064	0	6,257	146,948
11.00	01100	CAFETERIA	37,086	8,892	0	0	0
13.00	01300	NURSING ADMINISTRATION	890	3,387	0	1,669	0
14.00	01400	CENTRAL SERVICES & SUPPLY	9,292	0	432	1,877	0
15.00	01500	PHARMACY	99,363	16,008	0	4,797	0
16.00	01600	MEDICAL RECORDS & LIBRARY	44,299	22,148	0	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	329,516	212,363	38,956	101,575	141,856
31.00	03100	INTENSIVE CARE UNIT	19,656	30,016	393	3,129	5,092
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	256,073	112,737	11,390	28,366	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	21,631	1,588	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	176,920	54,493	9,326	23,360	0
56.00	05600	RADIOISOTOPE	40,724	3,176	0	0	0
56.01	05602	ULTRASOUND	36,303	2,752	0	0	0
57.00	05700	CT SCAN	56,401	4,446	0	2,503	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	91,193	9,104	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	263,445	23,241	0	12,097	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	14,043	2,117	0	0	0
65.00	06500	RESPIRATORY THERAPY	39,854	6,563	0	0	0
66.00	06600	PHYSICAL THERAPY	152,314	39,614	9,876	10,011	0
67.00	06700	OCCUPATIONAL THERAPY	41,167	3,599	0	2,294	0
68.00	06800	SPEECH PATHOLOGY	23,174	1,270	0	1,669	0
69.01	06901	CARDIO-PULMONARY	36,584	19,572	7,361	2,920	0
69.02	06902	VASCULAR LAB	15,137	1,270	0	2,711	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,623	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01	07301	ONCOLOGY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	272,511	110,373	344	7,926	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
91.00	09100	EMERGENCY	301,618	83,074	894	23,152	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
116.00	11600	HOSPICE	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,698,426	812,098	92,740	236,313	146,948
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,951	10,762	0	0	0
190.01	19001	FOUNDATION	5,439	0	0	0	0
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	9,593	0	0	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,430	30,604	0	2,920	0
200.00		Cross Foot Adjustments	0	0	0	0	0
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	2,733,839	853,464	92,740	239,233	146,948

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet B
Part I
Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	158,843					11.00
13.00	01300		8,655				13.00
14.00	01400			40,751			14.00
15.00	01500		353		426,561		15.00
16.00	01600					206,449	16.00
17.00	01700						17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	30,852	2,990	1,543		11,806	30.00
31.00	03100	90	9	343		518	31.00
41.00	04100						41.00
42.00	04200						42.00
43.00	04300						43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	10,524	1,020	28,410		21,590	50.00
52.00	05200						52.00
53.00	05300	2,400				4,969	53.00
54.00	05400	11,255	1,091			13,865	54.00
56.00	05600					3,028	56.00
56.01	05602	3,658	355			4,762	56.01
57.00	05700	3,978	386			24,585	57.00
58.00	05800					7,330	58.00
59.00	05900						59.00
60.00	06000	16,083				46,365	60.00
60.01	06001						60.01
62.00	06200	242				698	62.00
65.00	06500	3,675	356			6,034	65.00
66.00	06600	14,823				9,454	66.00
67.00	06700	3,144				1,822	67.00
68.00	06800	2,027				444	68.00
69.01	06901	3,949	383	1,457		6,485	69.01
69.02	06902					1,437	69.02
71.00	07100						71.00
72.00	07200					180	72.00
73.00	07300				426,561	7,254	73.00
73.01	07301						73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	23,755		4,199		7,406	88.00
89.00	08900						89.00
91.00	09100	17,659	1,712	4,799		26,417	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600						96.00
99.10	09910						99.10
101.00	10100						101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900						109.00
110.00	11000						110.00
111.00	11100						111.00
116.00	11600						116.00
118.00		157,816	8,655	40,751	426,561	206,449	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	283					190.00
190.01	19001	744					190.01
190.02	19002						190.02
192.00	19200						192.00
200.00							200.00
201.00							201.00
202.00		158,843	8,655	40,751	426,561	206,449	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet B
Part I
Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,874,274	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	119,066	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,249,423	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	96,419	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	828,734	0	54.00
56.00	05600	RADIO-SOPE	0	170,865	0	56.00
56.01	05602	ULTRASOUND	0	158,312	0	56.01
57.00	05700	CT SCAN	0	263,945	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	385,158	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	1,162,979	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	59,837	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	177,770	0	65.00
66.00	06600	PHYSICAL THERAPY	0	699,634	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	177,311	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	99,110	0	68.00
69.01	06901	CARDIO-PULMONARY	0	190,048	0	69.01
69.02	06902	VASCULAR LAB	0	66,623	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,871	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	428,965	0	73.00
73.01	07301	ONCOLOGY	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,255,852	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100	EMERGENCY	0	1,377,248	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
99.10	09910	CORF	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	10,860,444	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	51,280	0	190.00
190.01	19001	FOUNDATION	0	22,735	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	38,787	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	75,695	0	192.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	11,048,941	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet B Part II Date/Time Prepared: 8/26/2014 8:37 am		
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			2.00
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,092	403	4,495
5.00	00500	ADMINISTRATIVE & GENERAL	0	143,607	9,731	153,338
7.00	00700	OPERATION OF PLANT	0	76,474	4,813	81,287
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,894	0	3,894
9.00	00900	HOUSEKEEPING	0	7,487	377	7,864
10.00	01000	DIETARY	0	20,845	3,817	24,662
11.00	01100	CAFETERIA	0	7,111	0	7,111
13.00	01300	NURSING ADMINISTRATION	0	2,709	0	2,709
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	4,532	4,532
15.00	01500	PHARMACY	0	12,802	1,965	14,767
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,712	1,797	19,509
17.00	01700	SOCIAL SERVICE	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	169,833	16,259	186,092
31.00	03100	INTENSIVE CARE UNIT	0	24,005	1,796	25,801
41.00	04100	SUBPROVIDER - IRF	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0
43.00	04300	NURSERY	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	90,160	67,411	157,571
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0
53.00	05300	ANESTHESIOLOGY	0	1,270	15,736	17,006
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	43,580	40,832	84,412
56.00	05600	RADIOISOTOPE	0	2,540	0	2,540
56.01	05602	ULTRASOUND	0	2,201	9,434	11,635
57.00	05700	CT SCAN	0	3,556	0	3,556
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	7,281	0	7,281
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0
60.00	06000	LABORATORY	0	18,587	16,382	34,969
60.01	06001	BLOOD LABORATORY	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,693	0	1,693
65.00	06500	RESPIRATORY THERAPY	0	5,249	0	5,249
66.00	06600	PHYSICAL THERAPY	0	31,681	8,313	39,994
67.00	06700	OCCUPATIONAL THERAPY	0	2,878	310	3,188
68.00	06800	SPEECH PATHOLOGY	0	1,016	449	1,465
69.01	06901	CARDIO-PULMONARY	0	15,652	24,373	40,025
69.02	06902	VASCULAR LAB	0	1,016	0	1,016
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0
73.01	07301	ONCOLOGY	0	0	0	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	88,270	1,246	89,516
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0
91.00	09100	EMERGENCY	0	66,437	29,092	95,529
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0
99.10	09910	CORF	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0
116.00	11600	HOSPICE	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	873,638	259,068	1,132,706
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,607	119	8,726
190.01	19001	FOUNDATION	0	0	1,598	1,598
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	9	9
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	24,475	259	24,734
200.00		Cross Foot Adjustments				0
201.00		Negative Cost Centers		0	0	0
202.00		TOTAL (sum lines 118-201)	0	906,720	261,053	1,167,773

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet B
Part II
Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	154,087					5.00
7.00	00700	OPERATION OF PLANT	11,897	93,318				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,225	532	5,651			8.00
9.00	00900	HOUSEKEEPING	3,012	1,024	839	12,836		9.00
10.00	01000	DIETARY	1,598	2,850	0	336	29,476	10.00
11.00	01100	CAFETERIA	2,090	972	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	50	370	0	90	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	524	0	26	101	0	14.00
15.00	01500	PHARMACY	5,600	1,750	0	257	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,497	2,422	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,574	23,221	2,374	5,450	28,455	30.00
31.00	03100	INTENSIVE CARE UNIT	1,108	3,282	24	168	1,021	31.00
41.00	04100	SUBPROVIDER - IIRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,433	12,327	694	1,522	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,219	174	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,972	5,958	568	1,253	0	54.00
56.00	05600	RADIOISOTOPE	2,295	347	0	0	0	56.00
56.01	05602	ULTRASOUND	2,046	301	0	0	0	56.01
57.00	05700	CT SCAN	3,179	486	0	134	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	5,140	995	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	14,848	2,541	0	649	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	791	231	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	2,246	718	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	8,585	4,331	602	537	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,320	394	0	123	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,306	139	0	90	0	68.00
69.01	06901	CARDIO-PULMONARY	2,062	2,140	449	157	0	69.01
69.02	06902	VASCULAR LAB	853	139	0	145	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	261	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	15,359	12,068	21	425	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	17,000	9,083	54	1,242	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	152,090	88,795	5,651	12,679	29,476	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	561	1,177	0	0	0	190.00
190.01	19001	FOUNDATION	307	0	0	0	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	541	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	588	3,346	0	157	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	154,087	93,318	5,651	12,836	29,476	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet B Part II Date/Time Prepared: 8/26/2014 8:37 am
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	10,255					11.00
13.00	01300		3,219				13.00
14.00	01400	56	0	5,251			14.00
15.00	01500	235	131	0	22,819		15.00
16.00	01600	335	0	0	0	24,823	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,992	1,114	199	0	1,419	30.00
31.00	03100	6	3	44	0	62	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	679	379	3,661	0	2,596	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	155	0	0	0	597	53.00
54.00	05400	727	406	0	0	1,667	54.00
56.00	05600	0	0	0	0	364	56.00
56.01	05602	236	132	0	0	573	56.01
57.00	05700	257	143	0	0	2,956	57.00
58.00	05800	0	0	0	0	881	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	1,038	0	0	0	5,577	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	16	0	0	0	84	62.00
65.00	06500	237	132	0	0	725	65.00
66.00	06600	957	0	0	0	1,137	66.00
67.00	06700	203	0	0	0	219	67.00
68.00	06800	131	0	0	0	53	68.00
69.01	06901	255	142	188	0	780	69.01
69.02	06902	0	0	0	0	173	69.02
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	22	72.00
73.00	07300	0	0	0	22,819	872	73.00
73.01	07301	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,534	0	541	0	890	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	1,140	637	618	0	3,176	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	0	0	0	0	0	96.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
116.00	11600	0	0	0	0	0	116.00
118.00		10,189	3,219	5,251	22,819	24,823	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	18	0	0	0	0	190.00
190.01	19001	48	0	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		10,255	3,219	5,251	22,819	24,823	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet B Part II Date/Time Prepared: 8/26/2014 8:37 am
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Cost Center Description		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	0			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	269,628	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31,538	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	194,182	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	19,278	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	105,137	0	54.00
56.00	05600	RADIOISOTOPE	0	5,546	0	56.00
56.01	05602	ULTRASOUND	0	14,995	0	56.01
57.00	05700	CT SCAN	0	10,788	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	14,297	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	59,878	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,819	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	9,366	0	65.00
66.00	06600	PHYSICAL THERAPY	0	56,448	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	6,535	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,233	0	68.00
69.01	06901	CARDIO-PULMONARY	0	46,261	0	69.01
69.02	06902	VASCULAR LAB	0	2,359	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	283	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,691	0	73.00
73.01	07301	ONCOLOGY	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	120,841	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
91.00	09100	EMERGENCY	0	128,847	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
99.10	09910	CORF	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	111.00
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,125,950	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	10,485	0	190.00
190.01	19001	FOUNDATION	0	1,963	0	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	550	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	28,825	0	192.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,167,773	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141325

Period: From 10/01/2013 To 03/31/2014

Worksheet B-1

Date/Time Prepared: 8/26/2014 8:37 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (MME DEPRE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	96,394					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP		424,663				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	435	655	4,914,836			4.00
5.00 00500	ADMINISTRATIVE & GENERAL	15,267	15,829	821,888	-2,733,839	8,319,952	5.00
7.00 00700	OPERATION OF PLANT	8,130	7,829	146,529	0	642,384	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	414	0	0	0	66,139	8.00
9.00 00900	HOUSEKEEPING	796	613	105,992	0	162,656	9.00
10.00 01000	DIETARY	2,216	6,210	32,546	0	86,277	10.00
11.00 01100	CAFETERIA	756	0	89,141	0	112,865	11.00
13.00 01300	NURSING ADMINISTRATION	288	0	0	0	2,709	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	7,373	13,557	0	28,278	14.00
15.00 01500	PHARMACY	1,361	3,197	86,541	0	302,395	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,883	2,924	65,245	0	134,817	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	18,055	26,449	806,317	0	1,002,817	30.00
31.00 03100	INTENSIVE CARE UNIT	2,552	2,921	20,896	0	59,820	31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	9,585	109,658	349,491	0	779,313	50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	135	25,599	138,362	0	65,831	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	4,633	66,422	190,060	0	538,424	54.00
56.00 05600	RADIOISOTOPE	270	0	0	0	123,937	56.00
56.01 05602	ULTRASOUND	234	15,347	79,155	0	110,482	56.01
57.00 05700	CT SCAN	378	0	83,879	0	171,646	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	774	0	0	0	277,531	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000	LABORATORY	1,976	26,649	279,740	0	801,748	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	4,211	0	42,737	62.00
65.00 06500	RESPIRATORY THERAPY	558	0	64,208	0	121,288	65.00
66.00 06600	PHYSICAL THERAPY	3,368	13,523	333,857	0	463,542	66.00
67.00 06700	OCCUPATIONAL THERAPY	306	504	95,740	0	125,285	67.00
68.00 06800	SPEECH PATHOLOGY	108	731	53,713	0	70,526	68.00
69.01 06901	CARDIO-PULMONARY	1,664	39,648	69,009	0	111,337	69.01
69.02 06902	VASCULAR LAB	108	0	36,077	0	46,068	69.02
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	14,068	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,850	0	73.00
73.01 07301	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	9,384	2,027	532,725	0	829,338	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00 09100	EMERGENCY	7,063	47,325	402,421	0	917,923	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10 09910	CORF	0	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	0	111.00
116.00 11600	HOSPICE	0	0	0	0	0	116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	92,877	421,433	4,901,300	-2,728,989	8,212,181	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	915	193	2,993	0	30,284	190.00
190.01 19001	FOUNDATION	0	2,600	10,543	0	16,552	190.01
190.02 19002	DURABLE MEDICAL EQUIP-RENTED	0	15	0	0	29,194	190.02
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,602	422	0	0	31,741	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	906,720	261,053	1,222,706		2,733,839	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	9.406395	0.614730	0.248779		0.328588	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet B-1
Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (MME DEPRE)				
		1.00	2.00				
204.00	Cost to be allocated (per Wkst. B, Part II)			4,495		154,087	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000915		0.018520	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet B-1

Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)		
		7.00	8.00	9.00	10.00	11.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL					5.00	
7.00	00700	OPERATION OF PLANT	72,562				7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	414	9,437			8.00	
9.00	00900	HOUSEKEEPING	796	1,401	1,147		9.00	
10.00	01000	DIETARY	2,216	0	30	606	10.00	
11.00	01100	CAFETERIA	756	0	0	128,722	11.00	
13.00	01300	NURSING ADMINISTRATION	288	0	8	0	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	44	9	0	14.00	
15.00	01500	PHARMACY	1,361	0	23	0	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	1,883	0	0	0	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,055	3,964	487	585	25,002	30.00
31.00	03100	INTENSIVE CARE UNIT	2,552	40	15	21	73	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,585	1,159	136	0	8,528	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	135	0	0	0	1,945	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,633	949	112	0	9,121	54.00
56.00	05600	RADIO SOTOPE	270	0	0	0	0	56.00
56.01	05602	ULTRASOUND	234	0	0	0	2,964	56.01
57.00	05700	CT SCAN	378	0	12	0	3,224	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	774	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,976	0	58	0	13,033	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	180	0	0	0	196	62.00
65.00	06500	RESPIRATORY THERAPY	558	0	0	0	2,978	65.00
66.00	06600	PHYSICAL THERAPY	3,368	1,005	48	0	12,012	66.00
67.00	06700	OCCUPATIONAL THERAPY	306	0	11	0	2,548	67.00
68.00	06800	SPEECH PATHOLOGY	108	0	8	0	1,643	68.00
69.01	06901	CARDIO-PULMONARY	1,664	749	14	0	3,200	69.01
69.02	06902	VASCULAR LAB	108	0	13	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	9,384	35	38	0	19,250	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	7,063	91	111	0	14,310	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,045	9,437	1,133	606	127,890	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	915	0	0	0	229	190.00
190.01	19001	FOUNDATION	0	0	0	0	603	190.01
190.02	19002	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	190.02
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,602	0	14	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	853,464	92,740	239,233	146,948	158,843	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.761859	9.827276	208.572799	242.488449	1.234000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	93,318	5,651	12,836	29,476	10,255	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet B-1

Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DAYS)	CAFETERIA (FTE'S)	
		7.00	8.00	9.00	10.00	11.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	1.286045	0.598813	11.190933	48.640264	0.079668	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet B-1

Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		NURSING ADMINISTRATIVE (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (PRODUCTIVITY)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	72,354					13.00
14.00	01400	0	951				14.00
15.00	01500	2,954	0	100			15.00
16.00	01600	0	0	0	26,459,689		16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	25,002	36	0	1,513,193	0	30.00
31.00	03100	73	8	0	66,377	0	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	8,528	663	0	2,767,263	0	50.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	636,908	0	53.00
54.00	05400	9,121	0	0	1,777,052	0	54.00
56.00	05600	0	0	0	388,157	0	56.00
56.01	05602	2,964	0	0	610,381	0	56.01
57.00	05700	3,224	0	0	3,151,125	0	57.00
58.00	05800	0	0	0	939,549	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	5,941,376	0	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	0	0	89,432	0	62.00
65.00	06500	2,978	0	0	773,434	0	65.00
66.00	06600	0	0	0	1,211,723	0	66.00
67.00	06700	0	0	0	233,498	0	67.00
68.00	06800	0	0	0	56,869	0	68.00
69.01	06901	3,200	34	0	831,260	0	69.01
69.02	06902	0	0	0	184,124	0	69.02
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	23,036	0	72.00
73.00	07300	0	0	100	929,744	0	73.00
73.01	07301	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	98	0	949,277	0	88.00
89.00	08900	0	0	0	0	0	89.00
91.00	09100	14,310	112	0	3,385,911	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	0	0	0	0	0	96.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
116.00	11600	0	0	0	0	0	116.00
118.00		72,354	951	100	26,459,689	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	0	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
192.00	19200	0	0	0	0	0	192.00
200.00							200.00
201.00							201.00
202.00		8,655	40,751	426,561	206,449	0	202.00
203.00		0.119620	42.850683	4,265.610000	0.007802	0.000000	203.00
204.00		3,219	5,251	22,819	24,823	0	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet B-1

Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		NURSING ADMINISTRATION (NURSING FTE'S)	CENTRAL SERVICES & SUPPLY (PRODUCTIVITY)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.044490	5.521556	228.190000	0.000938	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet C
Part I
Date/Time Prepared:
8/26/2014 8:37 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	1,874,274	1,874,274	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	119,066	119,066	0	0	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	42.00
43.00	04300 NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1,249,423	1,249,423	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	96,419	96,419	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	828,734	828,734	0	0	54.00
56.00	05600 RADIO SOTOPE	170,865	170,865	0	0	56.00
56.01	05602 ULTRASOUND	158,312	158,312	0	0	56.01
57.00	05700 CT SCAN	263,945	263,945	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	385,158	385,158	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000 LABORATORY	1,162,979	1,162,979	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	59,837	59,837	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	177,770	177,770	0	0	65.00
66.00	06600 PHYSICAL THERAPY	699,634	699,634	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	177,311	177,311	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	99,110	99,110	0	0	68.00
69.01	06901 CARDIO-PULMONARY	190,048	190,048	0	0	69.01
69.02	06902 VASCULAR LAB	66,623	66,623	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18,871	18,871	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	428,965	428,965	0	0	73.00
73.01	07301 ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	1,255,852	1,255,852	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
91.00	09100 EMERGENCY	1,377,248	1,377,248	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	396,837	396,837	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
99.10	09910 CORF	0	0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	111.00
116.00	11600 HOSPICE	0	0	0	0	116.00
200.00	Subtotal (see instructions)	11,257,281	11,257,281	0	0	200.00
201.00	Less Observation Beds	396,837	396,837	0	0	201.00
202.00	Total (see instructions)	10,860,444	10,860,444	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 141325		Period: From 10/01/2013 To 03/31/2014		Worksheet C Part I Date/Time Prepared: 8/26/2014 8:37 am	
			Title XVIII		Hospital		Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,274,926		1,274,926			30.00
31.00	03100	INTENSIVE CARE UNIT	66,377		66,377			31.00
41.00	04100	SUBPROVIDER - IRF	0		0			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	0		0			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	298,281	2,468,982	2,767,263	0.451501	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	83,516	553,392	636,908	0.151386	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,703	1,730,349	1,777,052	0.466353	0.000000	54.00
56.00	05600	RADIOISOTOPE	12,582	375,575	388,157	0.440196	0.000000	56.00
56.01	05602	ULTRASOUND	14,196	596,185	610,381	0.259366	0.000000	56.01
57.00	05700	CT SCAN	44,560	3,106,565	3,151,125	0.083762	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,644	925,905	939,549	0.409939	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	338,359	5,603,017	5,941,376	0.195742	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	14,160	75,272	89,432	0.669078	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	410,072	363,362	773,434	0.229845	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	143,223	1,068,500	1,211,723	0.577388	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,578	148,920	233,498	0.759368	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1,998	54,871	56,869	1.742777	0.000000	68.00
69.01	06901	CARDIO-PULMONARY	85,648	745,612	831,260	0.228626	0.000000	69.01
69.02	06902	VASCULAR LAB	20,623	163,501	184,124	0.361838	0.000000	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,036	23,036	0.819196	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	309,430	620,314	929,744	0.461380	0.000000	73.00
73.01	07301	ONCOLOGY	0	0	0	0.000000	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	949,277	949,277			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
91.00	09100	EMERGENCY	99,867	3,286,044	3,385,911	0.406758	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	238,267	238,267	1.665514	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0			101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	3,362,743	23,096,946	26,459,689			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,362,743	23,096,946	26,459,689			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet C
Part I
Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		PPS Inpatient Ratio	Title XVII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
56.01	05602 ULTRASOUND	0.000000			56.01
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.01	06901 CARDIO-PULMONARY	0.000000			69.01
69.02	06902 VASCULAR LAB	0.000000			69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
73.01	07301 ONCOLOGY	0.000000			73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
99.10	09910 CORF				99.10
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION				109.00
110.00	11000 INTESTINAL ACQUISITION				110.00
111.00	11100 ISLET ACQUISITION				111.00
116.00	11600 HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet C
Part I
Date/Time Prepared:
8/26/2014 8:37 am

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00		4.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	1,874,274		1,874,274	0	1,874,274	30.00
31.00	03100 INTENSIVE CARE UNIT	119,066		119,066	0	119,066	31.00
41.00	04100 SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,249,423		1,249,423	0	1,249,423	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	96,419		96,419	0	96,419	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	828,734		828,734	0	828,734	54.00
56.00	05600 RADIO SOTOPE	170,865		170,865	0	170,865	56.00
56.01	05602 ULTRASOUND	158,312		158,312	0	158,312	56.01
57.00	05700 CT SCAN	263,945		263,945	0	263,945	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	385,158		385,158	0	385,158	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	1,162,979		1,162,979	0	1,162,979	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	59,837		59,837	0	59,837	62.00
65.00	06500 RESPIRATORY THERAPY	177,770	0	177,770	0	177,770	65.00
66.00	06600 PHYSICAL THERAPY	699,634	0	699,634	0	699,634	66.00
67.00	06700 OCCUPATIONAL THERAPY	177,311	0	177,311	0	177,311	67.00
68.00	06800 SPEECH PATHOLOGY	99,110	0	99,110	0	99,110	68.00
69.01	06901 CARDIO-PULMONARY	190,048		190,048	0	190,048	69.01
69.02	06902 VASCULAR LAB	66,623		66,623	0	66,623	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18,871		18,871	0	18,871	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	428,965		428,965	0	428,965	73.00
73.01	07301 ONCOLOGY	0		0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	1,255,852		1,255,852	0	1,255,852	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
91.00	09100 EMERGENCY	1,377,248		1,377,248	0	1,377,248	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	396,837		396,837	0	396,837	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
99.10	09910 CORF	0		0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	0		0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0		0	0	0	111.00
116.00	11600 HOSPICE	0		0	0	0	116.00
200.00	Subtotal (see instructions)	11,257,281	0	11,257,281	0	11,257,281	200.00
201.00	Less Observation Beds	396,837		396,837	0	396,837	201.00
202.00	Total (see instructions)	10,860,444	0	10,860,444	0	10,860,444	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet C
Part I
Date/Time Prepared:
8/26/2014 8:37 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,274,926		1,274,926		30.00
31.00	03100	INTENSIVE CARE UNIT	66,377		66,377		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	298,281	2,468,982	2,767,263	0.451501	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	83,516	553,392	636,908	0.151386	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	46,703	1,730,349	1,777,052	0.466353	54.00
56.00	05600	RADIOISOTOPE	12,582	375,575	388,157	0.440196	56.00
56.01	05602	ULTRASOUND	14,196	596,185	610,381	0.259366	56.01
57.00	05700	CT SCAN	44,560	3,106,565	3,151,125	0.083762	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	13,644	925,905	939,549	0.409939	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	338,359	5,603,017	5,941,376	0.195742	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	14,160	75,272	89,432	0.669078	62.00
65.00	06500	RESPIRATORY THERAPY	410,072	363,362	773,434	0.229845	65.00
66.00	06600	PHYSICAL THERAPY	143,223	1,068,500	1,211,723	0.577388	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,578	148,920	233,498	0.759368	67.00
68.00	06800	SPEECH PATHOLOGY	1,998	54,871	56,869	1.742777	68.00
69.01	06901	CARDIO-PULMONARY	85,648	745,612	831,260	0.228626	69.01
69.02	06902	VASCULAR LAB	20,623	163,501	184,124	0.361838	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,036	23,036	0.819196	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	309,430	620,314	929,744	0.461380	73.00
73.01	07301	ONCOLOGY	0	0	0	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	949,277	949,277	1.322956	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
91.00	09100	EMERGENCY	99,867	3,286,044	3,385,911	0.406758	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	238,267	238,267	1.665514	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	96.00
99.10	09910	CORF	0	0	0	0.000000	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0.000000	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
116.00	11600	HOSPICE	0	0	0		116.00
200.00		Subtotal (see instructions)	3,362,743	23,096,946	26,459,689		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	3,362,743	23,096,946	26,459,689		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet C
Part I
Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
56.00	05600 RADIOISOTOPE	0.000000			56.00
56.01	05602 ULTRASOUND	0.000000			56.01
57.00	05700 CT SCAN	0.000000			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000			58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000 LABORATORY	0.000000			60.00
60.01	06001 BLOOD LABORATORY	0.000000			60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
67.00	06700 OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800 SPEECH PATHOLOGY	0.000000			68.00
69.01	06901 CARDIO-PULMONARY	0.000000			69.01
69.02	06902 VASCULAR LAB	0.000000			69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
73.01	07301 ONCOLOGY	0.000000			73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
91.00	09100 EMERGENCY	0.000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000			96.00
99.10	09910 CORF				99.10
101.00	10100 HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUISITION				109.00
110.00	11000 INTESTINAL ACQUISITION				110.00
111.00	11100 ISLET ACQUISITION				111.00
116.00	11600 HOSPICE				116.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet D Part II Date/Time Prepared: 8/26/2014 8:37 am
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Cost Center Description		Capital Related Cost (from Wkst. C, 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	194,182	2,767,263	0.070171	127,323	8,934	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	19,278	636,908	0.030268	32,712	990	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	105,137	1,777,052	0.059164	25,999	1,538	54.00
56.00	05600 RADIOISOTOPE	5,546	388,157	0.014288	2,438	35	56.00
56.01	05602 ULTRASOUND	14,995	610,381	0.024567	7,794	191	56.01
57.00	05700 CT SCAN	10,788	3,151,125	0.003424	19,426	67	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	14,297	939,549	0.015217	13,089	199	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	59,878	5,941,376	0.010078	192,206	1,937	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2,819	89,432	0.031521	13,462	424	62.00
65.00	06500 RESPIRATORY THERAPY	9,366	773,434	0.012110	305,779	3,703	65.00
66.00	06600 PHYSICAL THERAPY	56,448	1,211,723	0.046585	42,149	1,964	66.00
67.00	06700 OCCUPATIONAL THERAPY	6,535	233,498	0.027987	15,642	438	67.00
68.00	06800 SPEECH PATHOLOGY	3,233	56,869	0.056850	342	19	68.00
69.01	06901 CARDIO-PULMONARY	46,261	831,260	0.055652	11,641	648	69.01
69.02	06902 VASCULAR LAB	2,359	184,124	0.012812	8,645	111	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	283	23,036	0.012285	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	23,691	929,744	0.025481	158,694	4,044	73.00
73.01	07301 ONCOLOGY	0	0	0.000000	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	120,841	949,277	0.127298	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
91.00	09100 EMERGENCY	128,847	3,385,911	0.038054	902	34	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	69,460	238,267	0.291522	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00	Total (lines 50-199)	894,244	25,118,386		978,243	25,276	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet D
Part IV
Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col 4)
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	05602	ULTRASOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.01	06901	CARDIO-PULMONARY	0	0	0	0	0	69.01
69.02	06902	VASCULAR LAB	0	0	0	0	0	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet D
Part IV
Date/Time Prepared:
8/26/2014 8:37 am

Cost Center Description		Title XVIII			Hospital		Cost	
		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	2,767,263	0.000000	0.000000	127,323	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	636,908	0.000000	0.000000	32,712	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,777,052	0.000000	0.000000	25,999	54.00
56.00	05600	RADIOISOTOPE	0	388,157	0.000000	0.000000	2,438	56.00
56.01	05602	ULTRASOUND	0	610,381	0.000000	0.000000	7,794	56.01
57.00	05700	CT SCAN	0	3,151,125	0.000000	0.000000	19,426	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	939,549	0.000000	0.000000	13,089	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	5,941,376	0.000000	0.000000	192,206	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	89,432	0.000000	0.000000	13,462	62.00
65.00	06500	RESPIRATORY THERAPY	0	773,434	0.000000	0.000000	305,779	65.00
66.00	06600	PHYSICAL THERAPY	0	1,211,723	0.000000	0.000000	42,149	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	233,498	0.000000	0.000000	15,642	67.00
68.00	06800	SPEECH PATHOLOGY	0	56,869	0.000000	0.000000	342	68.00
69.01	06901	CARDIO-PULMONARY	0	831,260	0.000000	0.000000	11,641	69.01
69.02	06902	VASCULAR LAB	0	184,124	0.000000	0.000000	8,645	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,036	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	929,744	0.000000	0.000000	158,694	73.00
73.01	07301	ONCOLOGY	0	0	0.000000	0.000000	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	949,277	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
91.00	09100	EMERGENCY	0	3,385,911	0.000000	0.000000	902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	238,267	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	25,118,386			978,243	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet D Part IV Date/Time Prepared: 8/26/2014 8:37 am
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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)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600 RADIOISOTOPE	0	0	0		56.00
56.01	05602 ULTRASOUND	0	0	0		56.01
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
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
69.01	06901 CARDIO-PULMONARY	0	0	0		69.01
69.02	06902 VASCULAR LAB	0	0	0		69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01	07301 ONCOLOGY	0	0	0		73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet D Part V Date/Time Prepared: 8/26/2014 8:37 am
		Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.451501	0	1,039,252	0	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00 05300 ANESTHESIOLOGY	0.151386	0	211,815	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.466353	0	569,260	0	0 54.00
56.00 05600 RADIOISOTOPE	0.440196	0	184,341	0	0 56.00
56.01 05602 ULTRASOUND	0.259366	0	101,758	0	0 56.01
57.00 05700 CT SCAN	0.083762	0	1,075,355	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.409939	0	299,129	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00 06000 LABORATORY	0.195742	0	2,163,205	0	0 60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.669078	0	42,217	0	0 62.00
65.00 06500 RESPIRATORY THERAPY	0.229845	0	217,125	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.577388	0	296,668	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.759368	0	50,816	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	1.742777	0	14,398	0	0 68.00
69.01 06901 CARDIO-PULMONARY	0.228626	0	220,303	0	0 69.01
69.02 06902 VASCULAR LAB	0.361838	0	86,596	0	0 69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.819196	0	15,813	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.461380	0	225,065	5,182	0 73.00
73.01 07301 ONCOLOGY	0.000000	0	0	0	0 73.01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0 88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
91.00 09100 EMERGENCY	0.406758	0	965,308	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.665514	0	164,658	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0 96.00
200.00 Subtotal (see instructions)		0	7,943,082	5,182	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	7,943,082	5,182	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet D Part V Date/Time Prepared: 8/26/2014 8:37 am
		Title XVIII	Hospital	Cost

Cost Center Description	Costs		Hospital	Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	469,223	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	32,066	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	265,476	0		54.00
56.00 05600 RADIOISOTOPE	81,146	0		56.00
56.01 05602 ULTRASOUND	26,393	0		56.01
57.00 05700 CT SCAN	90,074	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	122,625	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	423,430	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	28,246	0		62.00
65.00 06500 RESPIRATORY THERAPY	49,905	0		65.00
66.00 06600 PHYSICAL THERAPY	171,293	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	38,588	0		67.00
68.00 06800 SPEECH PATHOLOGY	25,093	0		68.00
69.01 06901 CARDIO-PULMONARY	50,367	0		69.01
69.02 06902 VASCULAR LAB	31,334	0		69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	12,954	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	103,840	2,391		73.00
73.01 07301 ONCOLOGY	0	0		73.01
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00 09100 EMERGENCY	392,647	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	274,240	0		92.00
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	2,688,940	2,391		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	2,688,940	2,391		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141325 Component CCN: 14Z325	Period: From 10/01/2013 To 03/31/2014	Worksheet D Part V Date/Time Prepared: 8/26/2014 8:37 am
Title XVIII		Swing Beds - SNF	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.451501	0	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.151386	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.466353	0	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0.440196	0	0	0	0	56.00
56.01 05602 ULTRASOUND	0.259366	0	0	0	0	56.01
57.00 05700 CT SCAN	0.083762	0	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.409939	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00 06000 LABORATORY	0.195742	0	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.669078	0	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0.229845	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.577388	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.759368	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1.742777	0	0	0	0	68.00
69.01 06901 CARDIO-PULMONARY	0.228626	0	0	0	0	69.01
69.02 06902 VASCULAR LAB	0.361838	0	0	0	0	69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.819196	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.461380	0	0	0	0	73.00
73.01 07301 ONCOLOGY	0.000000	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000				0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
91.00 09100 EMERGENCY	0.406758	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.665514	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00	Subtotal (see instructions)	0	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges		0	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet D Part V Date/Time Prepared: 8/26/2014 8:37 am
		Component CCN: 14Z325	Title XVII I	Swing Beds - SNF
				Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00 05600 RADIOISOTOPE	0	0		56.00
56.01 05602 ULTRASOUND	0	0		56.01
57.00 05700 CT SCAN	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	0	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.01 06901 CARDIO-PULMONARY	0	0		69.01
69.02 06902 VASCULAR LAB	0	0		69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01 07301 ONCOLOGY	0	0		73.01
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet D Part V Date/Time Prepared: 8/26/2014 8:37 am
		Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.451501	0	476,588	0	0 50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00 05300 ANESTHESIOLOGY	0.151386	0	181,372	0	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.466353	0	455,549	0	0 54.00
56.00 05600 RADIOISOTOPE	0.440196	0	98,878	0	0 56.00
56.01 05602 ULTRASOUND	0.259366	0	156,957	0	0 56.01
57.00 05700 CT SCAN	0.083762	0	817,430	0	0 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.409939	0	244,825	0	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00 06000 LABORATORY	0.195742	0	1,272,466	0	0 60.00
60.01 06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.669078	0	0	0	0 62.00
65.00 06500 RESPIRATORY THERAPY	0.229845	0	221,205	0	0 65.00
66.00 06600 PHYSICAL THERAPY	0.577388	0	204,478	0	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0.759368	0	34,746	0	0 67.00
68.00 06800 SPEECH PATHOLOGY	1.742777	0	4,922	0	0 68.00
69.01 06901 CARDIO-PULMONARY	0.228626	0	0	0	0 69.01
69.02 06902 VASCULAR LAB	0.361838	0	0	0	0 69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.819196	0	0	0	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.461380	0	152,044	0	0 73.00
73.01 07301 ONCOLOGY	0.000000	0	0	0	0 73.01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	1.322956				0 88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
91.00 09100 EMERGENCY	0.406758	0	1,830,079	0	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.665514	0	65,026	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0 96.00
200.00 Subtotal (see instructions)		0	6,216,565	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	6,216,565	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet D Part V Date/Time Prepared: 8/26/2014 8:37 am
		Title XIX	Hospital	Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	215,180	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	27,457	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	212,447	0		54.00
56.00 05600 RADIOISOTOPE	43,526	0		56.00
56.01 05602 ULTRASOUND	40,709	0		56.01
57.00 05700 CT SCAN	68,470	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	100,363	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	249,075	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00 06500 RESPIRATORY THERAPY	50,843	0		65.00
66.00 06600 PHYSICAL THERAPY	118,063	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	26,385	0		67.00
68.00 06800 SPEECH PATHOLOGY	8,578	0		68.00
69.01 06901 CARDIO-PULMONARY	0	0		69.01
69.02 06902 VASCULAR LAB	0	0		69.02
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	70,150	0		73.00
73.01 07301 ONCOLOGY	0	0		73.01
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
91.00 09100 EMERGENCY	744,399	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	108,302	0		92.00
OTHER REIMBURSABLE COST CENTERS				
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00 Subtotal (see instructions)	2,083,947	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	2,083,947	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet D-1 Date/Time Prepared: 8/26/2014 8:37 am
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,000	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		788	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)		585	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		84	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)		84	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		22	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)		22	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		376	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)		84	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)		84	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		123.34	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		123.34	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,874,274	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)		2,713	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)		2,713	25.00
26.00	Total swing-bed cost (see instructions)		333,842	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,540,432	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		1,540,432	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,954.86	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		735,027	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)		735,027	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141325		Period: From 10/01/2013 To 03/31/2014		Worksheet D-1	
		Title XVIII		Hospital		Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	119,066	21	5,669.81	14	79,377	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)					317,746	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,132,150	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)					164,208	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					164,208	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					328,416	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)					203	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,954.86	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					396,837	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141325		Period: From 10/01/2013 To 03/31/2014		Worksheet D-1 Date/Time Prepared: 8/26/2014 8:37 am	
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	269,628	1,540,432	0.175034	396,837	69,460	90.00
91.00	Nursing School cost	0	1,540,432	0.000000	396,837	0	91.00
92.00	Allied health cost	0	1,540,432	0.000000	396,837	0	92.00
93.00	All other Medical Education	0	1,540,432	0.000000	396,837	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet D-1 Date/Time Prepared: 8/26/2014 8:37 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			1,000 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			788 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)			585 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			84 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)			84 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			22 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)			22 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			62 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			123.34 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			123.34 20.00
21.00	Total general inpatient routine service cost (see instructions)			1,874,274 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)			2,713 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)			2,713 25.00
26.00	Total swing-bed cost (see instructions)			333,842 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			1,540,432 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			1,540,432 37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,954.86 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			121,201 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)			121,201 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141325		Period: From 10/01/2013 To 03/31/2014		Worksheet D-1	
		Title XIX		Hospital		Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	119,066	21	5,669.81	1	5,670	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)					85,503	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					212,374	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					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)					203	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,954.86	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					396,837	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141325		Period: From 10/01/2013 To 03/31/2014		Worksheet D-1 Date/Time Prepared: 8/26/2014 8:37 am	
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	269,628	1,540,432	0.175034	396,837	69,460	90.00
91.00	Nursing School cost	0	1,540,432	0.000000	396,837	0	91.00
92.00	Allied health cost	0	1,540,432	0.000000	396,837	0	92.00
93.00	All other Medical Education	0	1,540,432	0.000000	396,837	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet D-3 Date/Time Prepared: 8/26/2014 8:37 am	
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		518,400	30.00
31.00	03100	INTENSIVE CARE UNIT		44,500	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.451501	127,323	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.151386	32,712	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.466353	25,999	54.00
56.00	05600	RADIOISOTOPE	0.440196	2,438	56.00
56.01	05602	ULTRASOUND	0.259366	7,794	56.01
57.00	05700	CT SCAN	0.083762	19,426	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.409939	13,089	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.195742	192,206	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.669078	13,462	62.00
65.00	06500	RESPIRATORY THERAPY	0.229845	305,779	65.00
66.00	06600	PHYSICAL THERAPY	0.577388	42,149	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.759368	15,642	67.00
68.00	06800	SPEECH PATHOLOGY	1.742777	342	68.00
69.01	06901	CARDIO-PULMONARY	0.228626	11,641	69.01
69.02	06902	VASCULAR LAB	0.361838	8,645	69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.819196	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.461380	158,694	73.00
73.01	07301	ONCOLOGY	0.000000	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
91.00	09100	EMERGENCY	0.406758	902	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.665514	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		978,243	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)		978,243	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet D-3	
		Component CCN: 14Z325		Date/Time Prepared: 8/26/2014 8:37 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.451501	2,164	977 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0.151386	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.466353	3,651	1,703 54.00
56.00	05600	RADIOISOTOPE	0.440196	0	0 56.00
56.01	05602	ULTRASOUND	0.259366	0	0 56.01
57.00	05700	CT SCAN	0.083762	0	0 57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.409939	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.195742	28,720	5,622 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.669078	0	0 62.00
65.00	06500	RESPIRATORY THERAPY	0.229845	51,426	11,820 65.00
66.00	06600	PHYSICAL THERAPY	0.577388	73,887	42,661 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.759368	49,441	37,544 67.00
68.00	06800	SPEECH PATHOLOGY	1.742777	972	1,694 68.00
69.01	06901	CARDIO-PULMONARY	0.228626	780	178 69.01
69.02	06902	VASCULAR LAB	0.361838	5,028	1,819 69.02
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.819196	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.461380	43,638	20,134 73.00
73.01	07301	ONCOLOGY	0.000000	0	0 73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
91.00	09100	EMERGENCY	0.406758	18	7 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.665514	0	0 92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0 96.00
200.00		Total (sum of lines 50-94 and 96-98)		259,725	124,159 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		259,725	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet D-3 Date/Time Prepared: 8/26/2014 8:37 am
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Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	Cost
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		91,447		30.00
31.00	03100 INTENSIVE CARE UNIT		3,110		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.451501	55,060	24,860	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.151386	27,428	4,152	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.466353	3,164	1,476	54.00
56.00	05600 RADIOISOTOPE	0.440196	852	375	56.00
56.01	05602 ULTRASOUND	0.259366	962	250	56.01
57.00	05700 CT SCAN	0.083762	3,019	253	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.409939	555	228	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.195742	28,420	5,563	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.669078	0	0	62.00
65.00	06500 RESPIRATORY THERAPY	0.229845	52,867	12,151	65.00
66.00	06600 PHYSICAL THERAPY	0.577388	748	432	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.759368	1,921	1,459	67.00
68.00	06800 SPEECH PATHOLOGY	1.742777	0	0	68.00
69.01	06901 CARDIO-PULMONARY	0.228626	0	0	69.01
69.02	06902 VASCULAR LAB	0.361838	0	0	69.02
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.819196	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.461380	30,350	14,003	73.00
73.01	07301 ONCOLOGY	0.000000	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.322956	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
91.00	09100 EMERGENCY	0.406758	49,910	20,301	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.665514	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		255,256	85,503	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		255,256		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet E Part B Date/Time Prepared: 8/26/2014 8:37 am
		Title XVII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2,691,331 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)			2,691,331 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 charge basis 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)			2,718,244 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)			21,623 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,152,145 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			1,544,476 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			1,544,476 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			1,544,476 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)			458,848 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			348,724 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			427,483 36.00
37.00	Subtotal (see instructions)			1,893,200 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)			1,893,200 40.00
40.01	Sequestration adjustment (see instructions)			37,864 40.01
41.00	Interim payments			2,046,408 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-191,072 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, section 115.2			89,294 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: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet E-1
Part I
Date/Time Prepared:
8/26/2014 8:37 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		890,105		2,046,408	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		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. E or Wkst. E-3, line and column as appropriate)		890,105		2,046,408		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		153,042		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		191,072		6.02
7.00	Total Medicare program liability (see instructions)		1,043,147		1,855,336		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141325

Period: From 10/01/2013

Worksheet E-1

Component CCN: 14Z325

To 03/31/2014

Part I
Date/Time Prepared:
8/26/2014 8:37 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		367,653		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		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. E or Wkst. E-3, line and column as appropriate)		367,653		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		79,001		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		446,654		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet E-1 Part II Date/Time Prepared: 8/26/2014 8:37 am
		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			0 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			0 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6. line 2			0 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			0 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			0 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			0 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			0 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			0 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet E-2
		Component CCN: 14Z325	Date/Time Prepared: 8/26/2014 8:37 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)	331,700	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)	125,401	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	168	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)	457,101	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	457,101	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)	457,101	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)	1,332	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)	455,769	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	455,769	0	19.00
19.01	Sequestration adjustment (see instructions)	9,115	0	19.01
20.00	Interim payments	367,653	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	79,001	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	15,045	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet E-3 Part V Date/Time Prepared: 8/26/2014 8:37 am
		Title VIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHs)				
1.00	Inpatient services			1,132,150 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)			1,132,150 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,143,472 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)			1,143,472 19.00
20.00	Deductibles (exclude professional component)			117,664 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,025,808 22.00
23.00	Coinurance			592 23.00
24.00	Subtotal (line 22 minus line 23)			1,025,216 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			51,605 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			39,220 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			43,063 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,064,436 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)			1,064,436 30.00
30.01	Sequestration adjustment (see instructions)			21,289 30.01
31.00	Interim payments			890,105 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			153,042 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			37,636 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet E-3 Part VII Date/Time Prepared: 8/26/2014 8:37 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		212,374		1.00
2.00	Medical and other services			2,083,947	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		212,374	2,083,947	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		212,374	2,083,947	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		159,583		8.00
9.00	Ancillary service charges		255,256	6,216,565	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		414,839	6,216,565	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		414,839	6,216,565	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		202,465	4,132,618	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		212,374	2,083,947	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		212,374	2,083,947	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		212,374	2,083,947	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		212,374	2,083,947	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		212,374	2,083,947	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		212,374	2,083,947	40.00
41.00	Interim payments		77,462	1,011,466	41.00
42.00	Balance due provider/program (line 40 minus 41)		134,912	1,072,481	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet G

Date/Time Prepared:
8/26/2014 8:37 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	3,253,914	0	0	0	1.00
2.00	Temporary investments	15,026,838	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,235,198	0	0	0	4.00
5.00	Other receivable	503,788	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	363,719	0	0	0	7.00
8.00	Prepaid expenses	-2	0	0	0	8.00
9.00	Other current assets	612,939	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	24,996,394	0	0	0	11.00
FIXED ASSETS						
12.00	Land	588,318	0	0	0	12.00
13.00	Land improvements	854,467	0	0	0	13.00
14.00	Accumulated depreciation	-480,118	0	0	0	14.00
15.00	Buildings	19,781,051	0	0	0	15.00
16.00	Accumulated depreciation	-5,654,955	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	9,550,462	0	0	0	19.00
20.00	Accumulated depreciation	-3,238,932	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	15,093,272	0	0	0	23.00
24.00	Accumulated depreciation	-11,093,954	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	25,399,611	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	12,637,911	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	670,488	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	13,308,399	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	63,704,404	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,083,192	0	0	0	37.00
38.00	Salaries, wages, and fees payable	809,793	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	965,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	2,548,389	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,406,374	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	26,340,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	26,340,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	31,746,374	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	31,958,030				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)	31,958,030	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	63,704,404	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet G-1

Date/Time Prepared:
8/26/2014 8:37 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		31,037,219			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		417,165				2.00
3.00	Total (sum of line 1 and line 2)		31,454,384			0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	CONTRIBUTIONS	6,182		0		0	5.00
6.00	CHANGE IN UNREALIZED GAIN	697,464		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)		703,646			0	10.00
11.00	Subtotal (line 3 plus line 10)		32,158,030			0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	NET ASSET TRANSFER TO TRUST	200,000		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)		200,000			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		31,958,030			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	CONTRIBUTIONS		0				5.00
6.00	CHANGE IN UNREALIZED GAIN		0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	NET ASSET TRANSFER TO TRUST		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet G-2 Parts I & II Date/Time Prepared: 8/26/2014 8:37 am
Cost Center Description		Inpatient	Outpatient	Total
		1.00	2.00	3.00
PART I - PATIENT REVENUES				
General Inpatient Routine Services				
1.00	Hospital	1,400,274		1,400,274
2.00	SUBPROVIDER - IPF			
3.00	SUBPROVIDER - IRF	0		0
4.00	SUBPROVIDER	0		0
5.00	Swing bed - SNF	226,230		226,230
6.00	Swing bed - NF	0		0
7.00	SKILLED NURSING FACILITY			
8.00	NURSING FACILITY			
9.00	OTHER LONG TERM CARE			
10.00	Total general inpatient care services (sum of lines 1-9)	1,626,504		1,626,504
Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	66,377		66,377
12.00	CORONARY CARE UNIT			
13.00	BURN INTENSIVE CARE UNIT			
14.00	SURGICAL INTENSIVE CARE UNIT			
15.00	OTHER SPECIAL CARE (SPECIFY)			
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	66,377		66,377
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,692,881		1,692,881
18.00	Ancillary services	1,751,287	24,863,505	26,614,792
19.00	Outpatient services	0	0	0
20.00	RURAL HEALTH CLINIC	0	949,277	949,277
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0
22.00	HOME HEALTH AGENCY		0	0
23.00	AMBULANCE SERVICES			
24.00	CMHC			
24.10	CORF	0	0	0
25.00	AMBULATORY SURGICAL CENTER (D.P.)			
26.00	HOSPICE	0	0	0
27.00	DIETARY	73	11,427	11,500
27.01	NURSERY	0	0	0
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,444,241	25,824,209	29,268,450
PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,360,301	
30.00	ADD (SPECIFY)	0		
31.00		0		
32.00		0		
33.00		0		
34.00		0		
35.00		0		
36.00	Total additions (sum of lines 30-35)		0	
37.00	DEDUCT (SPECIFY)	0		
38.00		0		
39.00		0		
40.00		0		
41.00		0		
42.00	Total deductions (sum of lines 37-41)		0	
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		13,360,301	

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141325

Period:
From 10/01/2013
To 03/31/2014

Worksheet G-3

Date/Time Prepared:
8/26/2014 8:37 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	29,268,450	1.00
2.00	Less contractual allowances and discounts on patients' accounts	16,409,248	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,859,202	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,360,301	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-501,099	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	690,221	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00		0	24.00
24.01	OTHER REVENUE	224,043	24.01
24.02	GAIN ON DISPOSAL OF EQUIPMENT	4,000	24.02
25.00	Total other income (sum of lines 6-24)	918,264	25.00
26.00	Total (line 5 plus line 25)	417,165	26.00
27.00		0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	417,165	29.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141325 Component CCN: 143445	Period: From 10/01/2013 To 03/31/2014	Worksheet M-1 Date/Time Prepared: 8/26/2014 8:37 am
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I 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	211,832	0	211,832	-73,911	137,921	1.00
2.00	Physician Assistant	201,663	0	201,663	0	201,663	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	230,145	0	230,145	0	230,145	9.00
10.00	Subtotal (sum of lines 1-9)	643,640	0	643,640	-73,911	569,729	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	9,851	9,851	0	9,851	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	28,823	28,823	-1,112	27,711	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	38,674	38,674	-1,112	37,562	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	643,640	38,674	682,314	-75,023	607,291	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	643,640	38,674	682,314	-75,023	607,291	32.00

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

Provider CCN: 141325

Period: From 10/01/2013

Worksheet M-1

Component CCN: 143445

To 03/31/2014

Date/Time Prepared: 8/26/2014 8:37 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	137,921	1.00
2.00	Physician Assistant	0	201,663	2.00
3.00	Nurse Practitioner	0	0	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	230,145	9.00
10.00	Subtotal (sum of lines 1-9)	0	569,729	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11-13)	0	0	14.00
15.00	Medical Supplies	0	9,851	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	27,711	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	37,562	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	607,291	22.00
COSTS OTHER THAN RHC/FOHC SERVICES				
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	607,291	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet M-2		
		Component CCN: 143445		Date/Time Prepared: 8/26/2014 8:37 am		
			Rural Health Clinic (RHC) I	Cost		
	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.23	790	4,200	966	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	2.00	4,778	2,100	4,200	3.00
4.00	Subtotal (sum of lines 1-3)	2.23	5,568		5,166	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	2.23	5,568			8.00
9.00	Physician Services Under Agreements		116		116	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)				607,291	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)				0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				607,291	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)				0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				648,561	15.00
16.00	Total overhead (sum of lines 14 and 15)				648,561	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtract line 17 from line 16				648,561	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				648,561	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,255,852	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141325	Period: From 10/01/2013 To 03/31/2014	Worksheet M-3
		Component CCN: 143445		Date/Time Prepared: 8/26/2014 8:37 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Worksheet M-2, line 20)		1,255,852	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,255,852	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		5,568	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		116	5.00
6.00	Total adjusted visits (line 4 plus line 5)		5,684	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		220.95	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or 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)	220.95	220.95	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	361	361	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	79,763	79,763	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) *		159,526	16.00
16.01	Total program charges (see instructions)(from contractor's records)		92,499	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		5,949	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		10,260	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.)		110,538	16.04
16.05	Total program cost (see instructions)		120,798	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		11,094	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		15,091	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		120,798	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		120,798	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		120,798	26.00
26.01	Sequestration adjustment (see instructions)		2,416	26.01
27.00	Interim payments		110,881	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		7,501	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, section 115.2		4,262	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141325 Component CCN: 143445	Period: From 10/01/2013 To 03/31/2014	Worksheet M-5 Date/Time Prepared: 8/26/2014 8:37 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		110,881	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		110,881	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		7,501	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		118,382	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00