This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 151307	Period: From 07/01/2013 To 06/30/2014	Worksheet S Parts I-III Date/Time Prepared: 11/25/2014 8:34 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/25/2014 Time: 8:34 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ST. VINCENT WILLIAMSPORT HOSPITAL (151307) for the cost reporting period beginning 07/01/2013 and ending 06/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-124,592	-162,612	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-15,849	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-60,424		0	10.00
10.01	RURAL HEALTH CLINIC II	0		18,314		0	10.01
200.00	Total	0	-140,441	-204,722	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 11/25/2014 8:32 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 412 NORTH MONROE	PO Box:			1.00
2.00	City: WILLIAMSPORT	State: IN	Zip Code: 47993	County: WARREN	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	ST. VINCENT WILLIAMSPORT HOSPITAL	151307	99915	1	07/01/1966	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	ST. VINCENT WILLIAMSPORT SWING BEDS	15Z307	99915		02/01/1988	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	NORTH CLINIC	153993	99915		05/06/2001	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	SOUTH CLINIC	153994	99915		08/01/2001	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2013	06/30/2014	20.00
21.00	Type of Control (see instructions)	6		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2014 8:32 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2014 8:32 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Non-Provider Settings					
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2014 8:32 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2014 8:32 am

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	10,543	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2014 8:32 am

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	15H046	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: ST. VINCENT HEALTH	Contractor's Name: WPS	Contractor's Number: 08101	141.00
142.00	Street: 10330 N. MERIDIAN ST. SUITE 420	PO Box:		142.00
143.00	City: INDIANAPOLIS	State: IN	Zip Code: 46290	143.00

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 11/25/2014 8:32 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	10/21/2014	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 11/25/2014 8:32 am

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JILL	HILL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ST. VINCENT HEALTH		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	3175833519	JILL.HILL@STVINCENT.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 11/25/2014 8:32 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	10/21/2014			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 11/25/2014 8:32 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	16	5,840	43,224.00	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)		16	5,840	43,224.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		16	5,840	43,224.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		16				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/25/2014 8:32 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,363	73	1,801			1.00
2.00	HMO and other (see instructions)	161	49				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	681	0	681			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	68			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,044	73	2,550			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)	2,044	73	2,550	0.00	134.34	14.00
15.00	CAH visits	26,806	4,073	70,766			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3,886	5,524	17,784	0.00	16.48	26.00
26.01	RURAL HEALTH CLINIC II	5,162	4,010	14,434	0.00	17.45	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	168.27	27.00
28.00	Observation Bed Days		0	819			28.00
29.00	Ambulance Trips	459					29.00
30.00	Employee discount days (see instruction)			8			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: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 11/25/2014 8:32 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	420	18	568	1.00
2.00	HMO and other (see instructions)			40	17		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	420	18	568	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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

Provider CCN: 151307 Component CCN: 153993

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

Worksheet S-8

Date/Time Prepared: 11/25/2014 8:32 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1731 RINGER LANE	1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	WILLIAMSPORT	IN	47993	2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
9.01		0		9.01
9.02		0		9.02
9.03		0		9.03
9.04		0		9.04
9.05		0		9.05
9.06		0		9.06
9.07		0		9.07
9.08		0		9.08
9.09		0		9.09
9.10		0		9.10
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	08:00	11.00

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

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

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

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

Provider CCN: 151307
Component CCN: 153993

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

Worksheet S-8
Date/Time Prepared: 11/25/2014 8:32 am

Rural Health Clinic (RHC) I

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		WARREN				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	08:00	17:00	08:00	16:30	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:30				11.00

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

Provider CCN: 151307 Component CCN: 153994

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

Worksheet S-8

Date/Time Prepared: 11/25/2014 8:32 am

		Rural Health Clinic (RHC) II	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	440 W. SONGER LANE	1.00
	City	State	Zip Code
	1.00	2.00	3.00
2.00	City, State, Zip Code, County	VEEDERSBURG IN	47987 2.00
			1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0 3.00
		Grant Award	Date
		1.00	2.00
	Source of Federal Funds		
4.00	Community Health Center (Section 330(d), PHS Act)	0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0	6.00
7.00	Appalachian Regional Commission	0	7.00
8.00	Look-Alikes	0	8.00
9.00	OTHER (SPECIFY)	0	9.00
9.01		0	9.01
9.02		0	9.02
9.03		0	9.03
9.04		0	9.04
9.05		0	9.05
9.06		0	9.06
9.07		0	9.07
9.08		0	9.08
9.09		0	9.09
9.10		0	9.10
		1.00	2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0 10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:30	17:00	07:30	11.00

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

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number			14.00

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

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

Provider CCN: 151307
Component CCN: 153994

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

Worksheet S-8
Date/Time Prepared: 11/25/2014 8:32 am

Rural Health Clinic (RHC) II

Cost

			County				
			4.00				
2.00	City, State, Zip Code, County		FOUNTAIN				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	07:30	17:00	07:30	16:30	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:30	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet S-10 | Date/Time Prepared: 11/25/2014 8:32 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.293662	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	421,922	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	9,274,159	6.00
7.00	Medicaid cost (line 1 times line 6)	2,723,468	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	2,301,546	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	14,444	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,301,546	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	3,941,651	8,295	3,949,946	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,157,513	2,436	1,159,949	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,157,513	2,436	1,159,949	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)	2,091,647	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	258,222	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,833,425	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	538,407	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,698,356	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,999,902	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/25/2014 8:32 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		283,646	283,646	118,646	402,292	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		746,594	746,594	0	746,594	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	56,244	2,503,278	2,559,522	0	2,559,522	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,641,611	2,663,292	4,304,903	-119,188	4,185,715	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	111,018	999,503	1,110,521	-14	1,110,507	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	258,325	258,325	-7	258,318	9.00
10.00	01000	DIETARY	0	17,888	17,888	0	17,888	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	146,311	30,102	176,413	-36	176,377	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,911	16,911	0	16,911	14.00
15.00	01500	PHARMACY	154,987	259,462	414,449	-1,125	413,324	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	216,392	47,863	264,255	0	264,255	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,098,502	205,260	1,303,762	-16,917	1,286,845	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	562,126	276,904	839,030	-33,875	805,155	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	531,345	226,940	758,285	-1,299	756,986	54.00
60.00	06000	LABORATORY	430,681	574,029	1,004,710	-4,758	999,952	60.00
65.00	06500	RESPIRATORY THERAPY	18,968	14,994	33,962	-3,006	30,956	65.00
66.00	06600	PHYSICAL THERAPY	247,311	23,426	270,737	-1,238	269,499	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	31,226	31,226	94,291	125,517	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	31,301	31,301	0	31,301	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,062,277	162,213	1,224,490	-37,693	1,186,797	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,117,987	131,370	1,249,357	-74,675	1,174,682	88.01
91.00	09100	EMERGENCY	687,541	899,511	1,587,052	-22,334	1,564,718	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	386,384	56,998	443,382	-2,830	440,552	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,469,685	10,461,036	18,930,721	-106,058	18,824,663	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	152,743	3,584	156,327	107,779	264,106	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	390,179	34,924	425,103	-1,721	423,382	193.01
193.02	19303	COMMUNITY MED CLINIC	0	105,474	105,474	0	105,474	193.02
194.00	07950	MARKETING	7,693	189	7,882	0	7,882	194.00
200.00		TOTAL (SUM OF LINES 118-199)	9,020,300	10,605,207	19,625,507	0	19,625,507	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A | Date/Time Prepared: 11/25/2014 8:32 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	-118,646	283,646		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	746,594		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	669,028	3,228,550		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-238,459	3,947,256		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	-2,447	1,108,060		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	258,318		9.00
10.00	01000	DIETARY	-7,061	10,827		10.00
11.00	01100	CAFETERIA	0	0		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	-500	175,877		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	16,911		14.00
15.00	01500	PHARMACY	-535	412,789		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,653	256,602		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		22.00
23.00	02300	PARAMED ED PRGM	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,286,845		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-222,621	582,534		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-151,999	604,987		54.00
60.00	06000	LABORATORY	-20,344	979,608		60.00
65.00	06500	RESPIRATORY THERAPY	0	30,956		65.00
66.00	06600	PHYSICAL THERAPY	-2,312	267,187		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	125,517		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	31,301		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	1,186,797		88.00
88.01	08801	RURAL HEALTH CLINIC II	-73	1,174,609		88.01
91.00	09100	EMERGENCY	0	1,564,718		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	440,552		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-103,622	18,721,041		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	264,106		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	ORTHO CLINIC	0	423,382		193.01
193.02	19303	COMMUNITY MED CLINIC	0	105,474		193.02
194.00	07950	MARKETING	92,230	100,112		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-11,392	19,614,115		200.00

RECLASSIFICATIONS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/25/2014 8:32 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	118,646		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	118,646		
	B - RHC RECLASS					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	107,963	0		1.00
2.00		0.00	0	0		2.00
	TOTALS		107,963	0		
	C - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	94,291		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
	TOTALS		0	94,291		
500.00	Grand Total: Increases		107,963	212,937		500.00

RECLASSIFICATIONS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-6 | Date/Time Prepared: 11/25/2014 8:32 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	118,646	10		1.00
2.00		0.00	0	0	10		2.00
	TOTALS		0	118,646			
	B - RHC RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	35,507	0	0		1.00
2.00	RURAL HEALTH CLINIC II	88.01	72,456	0	0		2.00
	TOTALS		107,963	0			
	C - MEDICAL SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	542	0		1.00
2.00	OPERATION OF PLANT	7.00	0	14	0		2.00
3.00	HOUSEKEEPING	9.00	0	7	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	36	0		4.00
5.00	PHARMACY	15.00	0	1,125	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	16,917	0		6.00
7.00	OPERATING ROOM	50.00	0	33,875	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,299	0		8.00
9.00	LABORATORY	60.00	0	4,758	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	3,006	0		10.00
11.00	PHYSICAL THERAPY	66.00	0	1,238	0		11.00
12.00	RURAL HEALTH CLINIC	88.00	0	2,186	0		12.00
13.00	RURAL HEALTH CLINIC II	88.01	0	2,219	0		13.00
14.00	EMERGENCY	91.00	0	22,334	0		14.00
15.00	AMBULANCE SERVICES	95.00	0	2,830	0		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	184	0		16.00
17.00	ORTHO CLINIC	193.01	0	1,721	0		17.00
	TOTALS		0	94,291			
500.00	Grand Total: Decreases		107,963	212,937			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 11/25/2014 8:32 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	174,050	0	0	0	0	1.00
2.00	Land Improvements	106,181	0	0	0	0	2.00
3.00	Buildings and Fixtures	8,177,698	152,217	0	152,217	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	4,793,989	31,724	0	31,724	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,251,918	183,941	0	183,941	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	13,251,918	183,941	0	183,941	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	174,050	0	1.00
2.00	Land Improvements	106,181	0	2.00
3.00	Buildings and Fixtures	8,329,915	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	4,825,713	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	13,435,859	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	13,435,859	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part II Date/Time Prepared: 11/25/2014 8:32 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	123,505	5,110	131,731	8,182	15,118	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	299,811	443,984	0	2,799	0	2.00
3.00	Total (sum of lines 1-2)	423,316	449,094	131,731	10,981	15,118	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	283,646		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	746,594		2.00
3.00	Total (sum of lines 1-2)	0	1,030,240		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 11/25/2014 8:32 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	8,610,146	0	8,610,146	0.640833	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	4,825,713	0	4,825,713	0.359167	0	2.00
3.00	Total (sum of lines 1-2)	13,435,859	0	13,435,859	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	123,505	5,110	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	299,811	443,984	2.00
3.00	Total (sum of lines 1-2)	0	0	0	423,316	449,094	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	131,731	8,182	15,118	0	283,646	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	2,799	0	0	746,594	2.00
3.00	Total (sum of lines 1-2)	131,731	10,981	15,118	0	1,030,240	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/25/2014 8:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-71,808	NEW CAP REL COSTS-BLDG & FIXT	1.00	10	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)	B	-7,919	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-394,964			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	1,859,382			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		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	-2,312	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8 | Date/Time Prepared: 11/25/2014 8:32 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	CHARITABLE CONTRIBUTIONS - MEALS	A	-5,332	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	CHARITABLE CONTRIBUTIONS / DONATIONS	A	-500	NURSING ADMINISTRATION	13.00	0	34.00
35.00			0		0.00	0	35.00
36.00	LOBBYING	A	-669	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	PROVIDER TAX	A	-1,365,753	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00			0		0.00	0	38.00
39.00	CREDENTIALING	B	-6,150	ADMINISTRATIVE & GENERAL	5.00	0	39.00
40.00	PHARMACY REVENUE	B	-535	PHARMACY	15.00	0	40.00
41.00	FOOD SERVICES	B	-7,061	DIETARY	10.00	0	41.00
42.00	MED. RECORD COPY REVENUE	B	-7,620	MEDICAL RECORDS & LIBRARY	16.00	0	42.00
43.00	OTHER NON-ALLOW REV	B	-40	ADMINISTRATIVE & GENERAL	5.00	0	43.00
43.01	HUMAN RESOURCES REVENUE	B	-5	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43.01
43.02	BUILDING RENTAL INCOME	B	-33	MEDICAL RECORDS & LIBRARY	16.00	0	43.02
44.00			0		0.00	0	44.00
45.00	ADVERTISING	A	-73	RURAL HEALTH CLINIC II	88.01	0	45.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,392				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-1 | Date/Time Prepared: 11/25/2014 8:32 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HO	0	71,737	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	HO	2,014,496	861,926	2.00
3.00	194.00	MARKETING	HO	92,230	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	SVH CHARGEBACKS	226,200	226,200	3.01
4.00	5.00	ADMINISTRATIVE & GENERAL	SVH CHARGEBACKS	1,121,835	1,121,835	4.00
4.01	7.00	OPERATION OF PLANT	SVH CHARGEBACKS	226,800	226,800	4.01
4.02	16.00	MEDICAL RECORDS & LIBRARY	SVH CHARGEBACKS	72,804	72,804	4.02
4.03	30.00	ADULTS & PEDIATRICS	SVH CHARGEBACKS	31,332	31,332	4.03
4.04	54.00	RADIOLOGY-DIAGNOSTIC	SVH CHARGEBACKS	15,744	15,744	4.04
4.05	4.00	EMPLOYEE BENEFITS DEPARTMENT	SELF INSURANCE	1,879,297	1,440,214	4.05
4.06	1.00	NEW CAP REL COSTS-BLDG & FIX	ASCENSION INTEREST	71,808	118,646	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	ASCENSION INTEREST	7,919	13,085	4.07
4.08	7.00	OPERATION OF PLANT	TRIMEDX	376,963	379,410	4.08
4.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	ASCENSION - PENSION	417,375	115,688	4.09
5.00	0		0	6,554,803	4,695,421	5.00

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

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

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

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

6.00	G	SVH	100.00	ST. VINCENT HEALTH	100.00	6.00
7.00	G	ASCENSION	100.00	ASCENSION	100.00	7.00
8.00	A	TRIMEDX	100.00	TRIMEDX	100.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	HOME OFFICE				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 151307	Period: From 07/01/2013 To 06/30/2014	Worksheet A-8-1 Date/Time Prepared: 11/25/2014 8:32 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-71,737	0		1.00
2.00	1,152,570	0		2.00
3.00	92,230	0		3.00
3.01	0	0		3.01
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	439,083	0		4.05
4.06	-46,838	10		4.06
4.07	-5,166	0		4.07
4.08	-2,447	0		4.08
4.09	301,687	0		4.09
5.00	1,859,382			5.00

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

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

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

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

6.00	ADMINISTRATION		6.00
7.00	ADMINISTRATION		7.00
8.00	TECHNOLOGY MGNT		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 11/25/2014 8:32 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	50.00	OPERATING ROOM	222,621	222,621	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	151,999	151,999	0	0	0	2.00
3.00	60.00	LABORATORY	20,344	20,344	0	0	0	3.00
4.00	91.00	EMERGENCY	771,375	0	771,375	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,166,339	394,964	771,375		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	0	0	222,621		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	151,999		2.00
3.00	60.00	LABORATORY	0	0	0	20,344		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	394,964		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/25/2014 8:32 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					7	1.00
2.00	Line 1 multiplied by 15 hours per week					105	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					15	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.21	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	0.00	218.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	0.00	57.79	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0.00	0.00	28.90			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					0	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					12,598	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					12,598	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					12,598	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					12,598	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					78	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					78	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					466	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/25/2014 8:32 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	0.00	57.79	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	12,598	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	466	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	13,064	63.00
64.00	Total cost of outside supplier services (from your records)	15,376	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	2,312	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	78	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	78	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	78	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	78	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	283,646	283,646				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	746,594		746,594			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,228,550	0	0	3,228,550		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,947,256	23,232	61,149	591,254	4,622,891	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,108,060	40,797	107,389	39,985	1,296,231	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,145	3,014	0	4,159	8.00
9.00	00900	HOUSEKEEPING	258,318	284	746	0	259,348	9.00
10.00	01000	DIETARY	10,827	0	0	0	10,827	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	175,877	3,037	7,993	52,696	239,603	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,911	0	0	0	16,911	14.00
15.00	01500	PHARMACY	412,789	0	0	55,821	468,610	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	256,602	9,759	25,688	77,937	369,986	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,286,845	34,758	91,487	395,643	1,808,733	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	582,534	23,843	62,757	202,459	871,593	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	604,987	16,248	42,766	191,372	855,373	54.00
60.00	06000	LABORATORY	979,608	8,135	21,412	155,117	1,164,272	60.00
65.00	06500	RESPIRATORY THERAPY	30,956	4,929	12,973	6,832	55,690	65.00
66.00	06600	PHYSICAL THERAPY	267,187	11,144	29,333	89,073	396,737	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	125,517	3,059	8,051	0	136,627	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	31,301	0	0	0	31,301	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,590	6,817	0	9,407	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,186,797	24,928	65,613	369,808	1,647,146	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,174,609	35,832	94,314	376,565	1,681,320	88.01
91.00	09100	EMERGENCY	1,564,718	14,072	37,040	247,629	1,863,459	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	440,552	15,986	42,077	139,162	637,777	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,721,041	273,778	720,619	2,991,353	18,448,001	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	264,106	7,126	18,757	93,897	383,886	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	423,382	2,704	7,118	140,529	573,733	193.01
193.02	19303	COMMUNITY MED CLINIC	105,474	0	0	0	105,474	193.02
194.00	07950	MARKETING	100,112	38	100	2,771	103,021	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	19,614,115	283,646	746,594	3,228,550	19,614,115	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,622,891					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	399,723	0	1,695,954			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,283	0	12,224	17,666		8.00
9.00	00900	HOUSEKEEPING	79,976	0	3,027	0	342,351	9.00
10.00	01000	DIETARY	3,339	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	73,887	0	32,422	0	4,765	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,215	0	0	0	0	14.00
15.00	01500	PHARMACY	144,507	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	114,094	0	104,193	0	15,313	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	557,764	0	371,078	8,303	54,538	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	268,776	0	254,544	2,650	37,411	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	263,774	0	173,460	883	25,494	54.00
60.00	06000	LABORATORY	359,030	0	86,847	0	12,764	60.00
65.00	06500	RESPIRATORY THERAPY	17,173	0	52,620	0	7,734	65.00
66.00	06600	PHYSICAL THERAPY	122,343	0	118,978	1,767	17,486	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	42,132	0	32,655	0	4,799	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	9,652	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,901	0	27,649	0	4,064	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	507,935	0	0	481	39,113	88.00
88.01	08801	RURAL HEALTH CLINIC II	518,474	0	0	402	56,223	88.01
91.00	09100	EMERGENCY	574,642	0	150,235	2,650	22,080	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	196,673	0	170,666	530	25,083	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,263,293	0	1,590,598	17,666	326,867	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	118,380	0	76,078	0	11,181	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	176,924	0	28,871	0	4,243	193.01
193.02	19303	COMMUNITY MED CLINIC	32,525	0	0	0	0	193.02
194.00	07950	MARKETING	31,769	0	407	0	60	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,622,891	0	1,695,954	17,666	342,351	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	14,166					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	350,677		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	22,126	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,166	0	0	153,145	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	45,866	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	65,901	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	3,242	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	17,710	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	4,416	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	82,523	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,166	0	0	350,677	22,126	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	0	0	0	0	0	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,166	0	0	350,677	22,126	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	613,117					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	603,586				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	40,122	0	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	37,260	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	151,563	0	0	0	54.00
60.00	06000	LABORATORY	0	134,174	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	13,583	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	23,769	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	613,117	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	30,164	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	26,305	0	0	0	88.01
91.00	09100	EMERGENCY	0	128,739	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	17,907	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	613,117	603,586	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	0	0	0	0	0	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	613,117	603,586	0	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	24.00	25.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0				22.00
23.00	02300	PARAMED ED PRGM	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	3,007,849	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	1,518,100	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	1,470,547	0	54.00
60.00	06000	LABORATORY	0	0	0	1,822,988	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	150,042	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	681,080	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	233,923	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	45,369	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	657,138	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	2,224,839	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	2,282,724	0	88.01
91.00	09100	EMERGENCY	0	0	0	2,824,328	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	1,048,636	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	17,967,563	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	589,525	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	0	0	0	783,771	0	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	137,999	0	193.02
194.00	07950	MARKETING	0	0	0	135,257	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	0	19,614,115	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part I | Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	Total		
			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
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
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			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
23.00	02300	PARAMED ED PRGM			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	3,007,849		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,518,100		50.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,470,547		54.00
60.00	06000	LABORATORY	1,822,988		60.00
65.00	06500	RESPIRATORY THERAPY	150,042		65.00
66.00	06600	PHYSICAL THERAPY	681,080		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	233,923		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	45,369		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,138		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	2,224,839		88.00
88.01	08801	RURAL HEALTH CLINIC II	2,282,724		88.01
91.00	09100	EMERGENCY	2,824,328		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	1,048,636		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,967,563		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	589,525		192.00
193.00	19300	NONPAID WORKERS	0		193.00
193.01	19301	ORTHO CLINIC	783,771		193.01
193.02	19303	COMMUNITY MED CLINIC	137,999		193.02
194.00	07950	MARKETING	135,257		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	19,614,115		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	331,024	23,232	61,149	415,405	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	40,797	107,389	148,186	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,145	3,014	4,159	0	8.00
9.00	00900	HOUSEKEEPING	0	284	746	1,030	0	9.00
10.00	01000	DIETARY	0	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	3,037	7,993	11,030	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,759	25,688	35,447	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	34,758	91,487	126,245	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	23,843	62,757	86,600	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,248	42,766	59,014	0	54.00
60.00	06000	LABORATORY	0	8,135	21,412	29,547	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	4,929	12,973	17,902	0	65.00
66.00	06600	PHYSICAL THERAPY	0	11,144	29,333	40,477	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,059	8,051	11,110	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,590	6,817	9,407	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	24,928	65,613	90,541	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	35,832	94,314	130,146	0	88.01
91.00	09100	EMERGENCY	0	14,072	37,040	51,112	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	15,986	42,077	58,063	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	331,024	273,778	720,619	1,325,421	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,126	18,757	25,883	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	0	2,704	7,118	9,822	0	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	0	38	100	138	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	331,024	283,646	746,594	1,361,264	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		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	415,405					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	35,919	0	184,105			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	115	0	1,327	5,601		8.00
9.00	00900	HOUSEKEEPING	7,187	0	329	0	8,546	9.00
10.00	01000	DIETARY	300	0	0	0	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	6,639	0	3,520	0	119	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	469	0	0	0	0	14.00
15.00	01500	PHARMACY	12,985	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,252	0	11,311	0	382	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,120	0	40,281	2,633	1,361	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,152	0	27,632	840	934	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,702	0	18,830	280	636	54.00
60.00	06000	LABORATORY	32,262	0	9,428	0	319	60.00
65.00	06500	RESPIRATORY THERAPY	1,543	0	5,712	0	193	65.00
66.00	06600	PHYSICAL THERAPY	10,994	0	12,916	560	437	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,786	0	3,545	0	120	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	867	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	261	0	3,001	0	101	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	45,642	0	0	153	976	88.00
88.01	08801	RURAL HEALTH CLINIC II	46,589	0	0	127	1,405	88.01
91.00	09100	EMERGENCY	51,635	0	16,309	840	551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	17,673	0	18,527	168	626	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	383,092	0	172,668	5,601	8,160	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,637	0	8,259	0	279	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	15,898	0	3,134	0	106	193.01
193.02	19303	COMMUNITY MED CLINIC	2,923	0	0	0	0	193.02
194.00	07950	MARKETING	2,855	0	44	0	1	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	415,405	0	184,105	5,601	8,546	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	300					10.00
11.00	01100	CAFETERIA	0	0				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	21,308		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	469	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	300	0	0	9,306	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	2,787	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	4,004	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	197	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	375	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	94	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	5,014	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	300	0	0	21,308	469	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	0	0	0	0	0	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	300	0	0	21,308	469	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	12,985					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	57,392				16.00
17.00	01700	SOCIAL SERVICE	0	0	0			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0			22.00
23.00	02300	PARAMED ED PRGM	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,815	0			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,542	0			50.00
53.00	05300	ANESTHESIOLOGY	0	0	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,417	0			54.00
60.00	06000	LABORATORY	0	12,756	0			60.00
65.00	06500	RESPIRATORY THERAPY	0	1,291	0			65.00
66.00	06600	PHYSICAL THERAPY	0	2,260	0			66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,985	0	0			73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,868	0			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,501	0			88.01
91.00	09100	EMERGENCY	0	12,240	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0			93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,702	0			95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,985	57,392	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
193.00	19300	NONPAID WORKERS	0	0	0			193.00
193.01	19301	ORTHO CLINIC	0	0	0			193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0			193.02
194.00	07950	MARKETING	0	0	0			194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,985	57,392	0	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	24.00	25.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		0				22.00
23.00	02300	PARAMED ED PRGM			0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				234,061	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM				146,487	0	50.00
53.00	05300	ANESTHESIOLOGY				0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				116,879	0	54.00
60.00	06000	LABORATORY				88,316	0	60.00
65.00	06500	RESPIRATORY THERAPY				26,838	0	65.00
66.00	06600	PHYSICAL THERAPY				67,644	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				18,936	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT				961	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				25,755	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				140,180	0	88.00
88.01	08801	RURAL HEALTH CLINIC II				180,768	0	88.01
91.00	09100	EMERGENCY				137,701	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER				0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES				96,759	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	0	1,281,285	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES				45,058	0	192.00
193.00	19300	NONPAID WORKERS				0	0	193.00
193.01	19301	ORTHO CLINIC				28,960	0	193.01
193.02	19303	COMMUNITY MED CLINIC				2,923	0	193.02
194.00	07950	MARKETING				3,038	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	0	1,361,264	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B Part II | Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	Total		
			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
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
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			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
23.00	02300	PARAMED ED PRGM			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	234,061		30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	146,487		50.00
53.00	05300	ANESTHESIOLOGY	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	116,879		54.00
60.00	06000	LABORATORY	88,316		60.00
65.00	06500	RESPIRATORY THERAPY	26,838		65.00
66.00	06600	PHYSICAL THERAPY	67,644		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,936		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	961		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,755		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	140,180		88.00
88.01	08801	RURAL HEALTH CLINIC II	180,768		88.01
91.00	09100	EMERGENCY	137,701		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	96,759		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,281,285		118.00
		NONREIMBURSABLE COST CENTERS			
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,058		192.00
193.00	19300	NONPAID WORKERS	0		193.00
193.01	19301	ORTHO CLINIC	28,960		193.01
193.02	19303	COMMUNITY MED CLINIC	2,923		193.02
194.00	07950	MARKETING	3,038		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	1,361,264		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	52,024					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		52,024				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	8,964,056			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,261	4,261	1,641,611	-4,622,891	14,991,224	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	7,483	7,483	111,018	0	1,296,231	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	210	210	0	0	4,159	8.00
9.00	00900	HOUSEKEEPING	52	52	0	0	259,348	9.00
10.00	01000	DIETARY	0	0	0	0	10,827	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	557	557	146,311	0	239,603	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	16,911	14.00
15.00	01500	PHARMACY	0	0	154,987	0	468,610	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,790	1,790	216,392	0	369,986	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,375	6,375	1,098,502	0	1,808,733	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,373	4,373	562,126	0	871,593	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,980	2,980	531,345	0	855,373	54.00
60.00	06000	LABORATORY	1,492	1,492	430,681	0	1,164,272	60.00
65.00	06500	RESPIRATORY THERAPY	904	904	18,968	0	55,690	65.00
66.00	06600	PHYSICAL THERAPY	2,044	2,044	247,311	0	396,737	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	561	561	0	0	136,627	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	31,301	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	475	475	0	0	9,407	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,572	4,572	1,026,770	0	1,647,146	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,572	6,572	1,045,531	0	1,681,320	88.01
91.00	09100	EMERGENCY	2,581	2,581	687,541	0	1,863,459	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,932	2,932	386,384	0	637,777	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,214	50,214	8,305,478	-4,622,891	13,825,110	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,307	1,307	260,706	0	383,886	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	496	496	390,179	0	573,733	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	105,474	193.02
194.00	07950	MARKETING	7	7	7,693	0	103,021	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	283,646	746,594	3,228,550		4,622,891	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.452214	14.350953	0.360166		0.308373	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		415,405	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.027710	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	29,136				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	210	90,075			8.00
9.00	00900	HOUSEKEEPING	0	52	0	40,018		9.00
10.00	01000	DIETARY	0	0	0	0	100	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	557	0	557	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,790	0	1,790	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,375	42,335	6,375	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,373	13,511	4,373	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,980	4,504	2,980	0	54.00
60.00	06000	LABORATORY	0	1,492	0	1,492	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	904	0	904	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,044	9,008	2,044	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	561	0	561	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	475	0	475	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	2,455	4,572	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	2,049	6,572	0	88.01
91.00	09100	EMERGENCY	0	2,581	13,511	2,581	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,932	2,702	2,932	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	27,326	90,075	38,208	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,307	0	1,307	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	0	496	0	496	0	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	0	7	0	7	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,695,954	17,666	342,351	14,166	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	58.208196	0.196125	8.554925	141.660000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	184,105	5,601	8,546	300	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	6.318815	0.062182	0.213554	3.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (DIRECT COSTS)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	0					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	0	0	109,793			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	156,818		14.00
15.00	01500	PHARMACY	0	0	0	0	100	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	47,948	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	14,360	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	20,633	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	1,015	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	125,517	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	31,301	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	100	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	25,837	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	109,793	156,818	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	0	0	0	0	0	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0	350,677	22,126	613,117	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	3.193983	0.141093	6,131.170000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0	21,308	469	12,985	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.194074	0.002991	129.850000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
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	56,205,040					16.00
17.00	01700	SOCIAL SERVICE	0	0				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0			0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0				22.00
23.00	02300	PARAMED ED PRGM	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,736,063	0		0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,469,636	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,113,454	0	0	0	0	54.00
60.00	06000	LABORATORY	12,494,047	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,264,806	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	2,213,309	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,808,838	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,449,458	0	0	0	0	88.01
91.00	09100	EMERGENCY	11,987,961	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,667,468	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	56,205,040	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ORTHO CLINIC	0	0	0	0	0	193.01
193.02	19303	COMMUNITY MED CLINIC	0	0	0	0	0	193.02
194.00	07950	MARKETING	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	603,586	0	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.010739	0.000000	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	57,392	0	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001021	0.000000	0.000000	0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet B-1 | Date/Time Prepared: 11/25/2014 8:32 am

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	PARAMED ED PRGM (ASSIGNED TIME)		
			22.00	23.00		
		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
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
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				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0			22.00
23.00	02300	PARAMED ED PRGM		0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	ORTHO CLINIC	0	0		193.01
193.02	19303	COMMUNITY MED CLINIC	0	0		193.02
194.00	07950	MARKETING	0	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/25/2014 8:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,007,849		3,007,849	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,518,100		1,518,100	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,470,547		1,470,547	0	0	54.00
60.00	06000	LABORATORY	1,822,988		1,822,988	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	150,042	0	150,042	0	0	65.00
66.00	06600	PHYSICAL THERAPY	681,080	0	681,080	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	233,923		233,923	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	45,369		45,369	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,138		657,138	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,224,839		2,224,839	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,282,724		2,282,724	0	0	88.01
91.00	09100	EMERGENCY	2,824,328		2,824,328	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	744,135		744,135		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,048,636		1,048,636	0	0	95.00
200.00		Subtotal (see instructions)	18,711,698	0	18,711,698	0	0	200.00
201.00		Less Observation Beds	744,135		744,135		0	201.00
202.00		Total (see instructions)	17,967,563	0	17,967,563	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/25/2014 8:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,805,672		2,805,672			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	201,650	3,267,986	3,469,636	0.437539	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	552,040	13,561,414	14,113,454	0.104195	0.000000	54.00
60.00	06000	LABORATORY	1,075,482	11,418,565	12,494,047	0.145909	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	672,912	591,894	1,264,806	0.118628	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	629,957	1,583,352	2,213,309	0.307720	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	665,610	906,726	1,572,336	0.148774	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	61,909	166,621	228,530	0.198525	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,236,081	1,942,575	3,178,656	0.206735	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,808,838	2,808,838			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,449,458	2,449,458			88.01
91.00	09100	EMERGENCY	0	11,987,961	11,987,961	0.235597	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	930,391	930,391	0.799809	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	104,982	1,562,486	1,667,468	0.628879	0.000000	95.00
200.00		Subtotal (see instructions)	8,006,295	53,178,267	61,184,562			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,006,295	53,178,267	61,184,562			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 151307	Period: From 07/01/2013 To 06/30/2014	Worksheet C Part I Date/Time Prepared: 11/25/2014 8:32 am
	Title XVIII	Hospital	Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/25/2014 8:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,007,849		3,007,849	0	3,007,849	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,518,100		1,518,100	0	1,518,100	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,470,547		1,470,547	0	1,470,547	54.00
60.00	06000	LABORATORY	1,822,988		1,822,988	0	1,822,988	60.00
65.00	06500	RESPIRATORY THERAPY	150,042	0	150,042	0	150,042	65.00
66.00	06600	PHYSICAL THERAPY	681,080	0	681,080	0	681,080	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	233,923		233,923	0	233,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	45,369		45,369	0	45,369	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,138		657,138	0	657,138	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,224,839		2,224,839	0	2,224,839	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,282,724		2,282,724	0	2,282,724	88.01
91.00	09100	EMERGENCY	2,824,328		2,824,328	0	2,824,328	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	744,135		744,135		744,135	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,048,636		1,048,636	0	1,048,636	95.00
200.00		Subtotal (see instructions)	18,711,698	0	18,711,698	0	18,711,698	200.00
201.00		Less Observation Beds	744,135		744,135		744,135	201.00
202.00		Total (see instructions)	17,967,563	0	17,967,563	0	17,967,563	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/25/2014 8:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,805,672		2,805,672			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	201,650	3,267,986	3,469,636	0.437539	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	552,040	13,561,414	14,113,454	0.104195	0.000000	54.00
60.00	06000	LABORATORY	1,075,482	11,418,565	12,494,047	0.145909	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	672,912	591,894	1,264,806	0.118628	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	629,957	1,583,352	2,213,309	0.307720	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	665,610	906,726	1,572,336	0.148774	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	61,909	166,621	228,530	0.198525	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,236,081	1,942,575	3,178,656	0.206735	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,808,838	2,808,838	0.792085	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,449,458	2,449,458	0.931930	0.000000	88.01
91.00	09100	EMERGENCY	0	11,987,961	11,987,961	0.235597	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	930,391	930,391	0.799809	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	104,982	1,562,486	1,667,468	0.628879	0.000000	95.00
200.00		Subtotal (see instructions)	8,006,295	53,178,267	61,184,562			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	8,006,295	53,178,267	61,184,562			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part I Date/Time Prepared: 11/25/2014 8:32 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part II Date/Time Prepared: 11/25/2014 8:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,518,100	146,487	1,371,613	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,470,547	116,879	1,353,668	0	0	54.00
60.00	06000	LABORATORY	1,822,988	88,316	1,734,672	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	150,042	26,838	123,204	0	0	65.00
66.00	06600	PHYSICAL THERAPY	681,080	67,644	613,436	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	233,923	18,936	214,987	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	45,369	961	44,408	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,138	25,755	631,383	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,224,839	140,180	2,084,659	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,282,724	180,768	2,101,956	0	0	88.01
91.00	09100	EMERGENCY	2,824,328	137,701	2,686,627	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	744,135	73,166	670,969	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,048,636	96,759	951,877	0	0	95.00
200.00		Subtotal (sum of lines 50 thru 199)	15,703,849	1,120,390	14,583,459	0	0	200.00
201.00		Less Observation Beds	744,135	73,166	670,969	0	0	201.00
202.00		Total (line 200 minus line 201)	14,959,714	1,047,224	13,912,490	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet C Part II Date/Time Prepared: 11/25/2014 8:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,518,100	3,469,636	0.437539		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,470,547	14,113,454	0.104195		54.00
60.00	06000	LABORATORY	1,822,988	12,494,047	0.145909		60.00
65.00	06500	RESPIRATORY THERAPY	150,042	1,264,806	0.118628		65.00
66.00	06600	PHYSICAL THERAPY	681,080	2,213,309	0.307720		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	233,923	1,572,336	0.148774		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	45,369	228,530	0.198525		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	657,138	3,178,656	0.206735		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,224,839	2,808,838	0.792085		88.00
88.01	08801	RURAL HEALTH CLINIC II	2,282,724	2,449,458	0.931930		88.01
91.00	09100	EMERGENCY	2,824,328	11,987,961	0.235597		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	744,135	930,391	0.799809		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,048,636	1,667,468	0.628879		95.00
200.00		Subtotal (sum of lines 50 thru 199)	15,703,849	58,378,890			200.00
201.00		Less Observation Beds	744,135	0			201.00
202.00		Total (line 200 minus line 201)	14,959,714	58,378,890			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/25/2014 8:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	146,487	3,469,636	0.042220	117,768	4,972	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	116,879	14,113,454	0.008281	354,063	2,932	54.00
60.00	06000	LABORATORY	88,316	12,494,047	0.007069	692,936	4,898	60.00
65.00	06500	RESPIRATORY THERAPY	26,838	1,264,806	0.021219	422,557	8,966	65.00
66.00	06600	PHYSICAL THERAPY	67,644	2,213,309	0.030562	224,136	6,850	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,936	1,572,336	0.012043	295,847	3,563	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	961	228,530	0.004205	32,945	139	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,755	3,178,656	0.008102	680,696	5,515	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	140,180	2,808,838	0.049907	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	180,768	2,449,458	0.073799	0	0	88.01
91.00	09100	EMERGENCY	137,701	11,987,961	0.011487	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	73,166	930,391	0.078640	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,023,631	56,711,422		2,820,948	37,835	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/25/2014 8:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/25/2014 8:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,469,636	0.000000	0.000000	117,768	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,113,454	0.000000	0.000000	354,063	54.00
60.00	06000	LABORATORY	0	12,494,047	0.000000	0.000000	692,936	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,264,806	0.000000	0.000000	422,557	65.00
66.00	06600	PHYSICAL THERAPY	0	2,213,309	0.000000	0.000000	224,136	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,572,336	0.000000	0.000000	295,847	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	228,530	0.000000	0.000000	32,945	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,178,656	0.000000	0.000000	680,696	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,808,838	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,449,458	0.000000	0.000000	0	88.01
91.00	09100	EMERGENCY	0	11,987,961	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	930,391	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	56,711,422			2,820,948	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/25/2014 8:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/25/2014 8:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.437539	0	1,159,604	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104195	0	4,309,379	0	0	54.00
60.00	06000	LABORATORY	0.145909	0	5,104,534	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.118628	0	591,894	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.307720	0	646,815	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148774	0	419,936	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.198525	0	50,986	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.206735	0	795,361	14,567	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	0.235597	0	3,156,349	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.799809	0	503,506	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.628879		0			95.00
200.00		Subtotal (see instructions)		0	16,738,364	14,567	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	16,738,364	14,567	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/25/2014 8:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	507,372	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	449,016	0		54.00
60.00	06000	LABORATORY	744,797	0		60.00
65.00	06500	RESPIRATORY THERAPY	70,215	0		65.00
66.00	06600	PHYSICAL THERAPY	199,038	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	62,476	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	10,122	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	164,429	3,012		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	743,626	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	402,709	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	3,353,800	3,012		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,353,800	3,012		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151307 | Component CCN: 15Z307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V Date/Time Prepared: 11/25/2014 8:32 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.437539	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104195	0	0	0	0	54.00
60.00	06000	LABORATORY	0.145909	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.118628	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.307720	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148774	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.198525	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.206735	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	0.235597	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.799809	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.628879		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151307 | Component CCN: 15Z307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part V | Date/Time Prepared: 11/25/2014 8:32 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part I Date/Time Prepared: 11/25/2014 8:32 am

Title XIX | Hospital | Cost

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	234,061	48,818	185,243	2,620	70.70	30.00
200.00	Total (lines 30-199)	234,061		185,243	2,620		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	73	5,161	30.00
200.00	Total (lines 30-199)	73	5,161	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part II Date/Time Prepared: 11/25/2014 8:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	146,487	3,469,636	0.042220	11,170	472	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	116,879	14,113,454	0.008281	36,246	300	54.00
60.00	06000	LABORATORY	88,316	12,494,047	0.007069	48,549	343	60.00
65.00	06500	RESPIRATORY THERAPY	26,838	1,264,806	0.021219	26,130	554	65.00
66.00	06600	PHYSICAL THERAPY	67,644	2,213,309	0.030562	12,496	382	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	18,936	1,572,336	0.012043	25,986	313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	961	228,530	0.004205	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,755	3,178,656	0.008102	83,648	678	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	140,180	2,808,838	0.049907	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	180,768	2,449,458	0.073799	0	0	88.01
91.00	09100	EMERGENCY	137,701	11,987,961	0.011487	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	73,166	930,391	0.078640	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,023,631	56,711,422		244,225	3,042	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part III Date/Time Prepared: 11/25/2014 8:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,620	0.00	73	0		30.00
200.00		Total (lines 30-199)	2,620		73	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/25/2014 8:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV Date/Time Prepared: 11/25/2014 8:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,469,636	0.000000	0.000000	11,170	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,113,454	0.000000	0.000000	36,246	54.00
60.00	06000	LABORATORY	0	12,494,047	0.000000	0.000000	48,549	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,264,806	0.000000	0.000000	26,130	65.00
66.00	06600	PHYSICAL THERAPY	0	2,213,309	0.000000	0.000000	12,496	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,572,336	0.000000	0.000000	25,986	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	228,530	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,178,656	0.000000	0.000000	83,648	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,808,838	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,449,458	0.000000	0.000000	0	88.01
91.00	09100	EMERGENCY	0	11,987,961	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	930,391	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	56,711,422			244,225	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D Part IV | Date/Time Prepared: 11/25/2014 8:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151307	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/25/2014 8:32 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,369	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,620	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,801	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	341	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)	340	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	34	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)	34	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,363	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)	341	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)	340	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	126.36	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	126.36	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,007,849	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)	4,296	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)	4,296	25.00
26.00	Total swing-bed cost (see instructions)	627,342	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,380,507	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,380,507	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)	908.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,238,408	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,238,408	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/25/2014 8:32 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	499,902	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,738,310	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)	309,829	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	308,921	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	618,750	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)	819	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	908.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	744,135	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/25/2014 8:32 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	234,061	2,380,507	0.098324	744,135	73,166	90.00
91.00	Nursing School cost	0	2,380,507	0.000000	744,135	0	91.00
92.00	Allied health cost	0	2,380,507	0.000000	744,135	0	92.00
93.00	All other Medical Education	0	2,380,507	0.000000	744,135	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 151307	Period: From 07/01/2013 To 06/30/2014	Worksheet D-1 Date/Time Prepared: 11/25/2014 8:32 am
	Title XIX	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,369	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,620	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,801	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	340	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)	341	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	34	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)	34	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	73	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	126.36	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	126.36	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,007,849	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)	4,296	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)	4,296	25.00
26.00	Total swing-bed cost (see instructions)	627,342	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,380,507	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,380,507	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)	908.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	66,327	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)	66,327	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/25/2014 8:32 am

Title XIX | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	43,852	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	110,179	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)	819	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	908.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	744,135	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-1 | Date/Time Prepared: 11/25/2014 8:32 am

Title XIX | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	234,061	2,380,507	0.098324	744,135	73,166	90.00
91.00	Nursing School cost	0	2,380,507	0.000000	744,135	0	91.00
92.00	Allied health cost	0	2,380,507	0.000000	744,135	0	92.00
93.00	All other Medical Education	0	2,380,507	0.000000	744,135	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/25/2014 8:32 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,543,844		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.437539	117,768	51,528	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104195	354,063	36,892	54.00
60.00	06000	LABORATORY	0.145909	692,936	101,106	60.00
65.00	06500	RESPIRATORY THERAPY	0.118628	422,557	50,127	65.00
66.00	06600	PHYSICAL THERAPY	0.307720	224,136	68,971	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148774	295,847	44,014	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.198525	32,945	6,540	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.206735	680,696	140,724	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.235597	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.799809	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,820,948	499,902	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)		2,820,948		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151307 | Component CCN: 15Z307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/25/2014 8:32 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.437539	34,249	14,985	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104195	72,413	7,545	54.00
60.00	06000	LABORATORY	0.145909	169,915	24,792	60.00
65.00	06500	RESPIRATORY THERAPY	0.118628	170,764	20,257	65.00
66.00	06600	PHYSICAL THERAPY	0.307720	306,353	94,271	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148774	121,167	18,026	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.198525	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.206735	264,769	54,737	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.235597	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.799809	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,139,630	234,613	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,139,630		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet D-3 | Date/Time Prepared: 11/25/2014 8:32 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		137,880		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.437539	11,170	4,887	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.104195	36,246	3,777	54.00
60.00	06000	LABORATORY	0.145909	48,549	7,084	60.00
65.00	06500	RESPIRATORY THERAPY	0.118628	26,130	3,100	65.00
66.00	06600	PHYSICAL THERAPY	0.307720	12,496	3,845	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.148774	25,986	3,866	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.198525	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.206735	83,648	17,293	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.792085	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.931930	0	0	88.01
91.00	09100	EMERGENCY	0.235597	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.799809	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		244,225	43,852	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)		244,225		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151307	Period: From 07/01/2013 To 06/30/2014	Worksheet E Part B Date/Time Prepared: 11/25/2014 8:32 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,356,812	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,356,812	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,390,380	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	25,432	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,348,769	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)	1,016,179	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)	1,016,179	30.00
31.00	Primary payer payments	27	31.00
32.00	Subtotal (line 30 minus line 31)	1,016,152	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)	281,201	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	247,457	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	192,653	36.00
37.00	Subtotal (see instructions)	1,263,609	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)	1,263,609	40.00
40.01	Sequestration adjustment (see instructions)	25,272	40.01
41.00	Interim payments	1,400,949	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-162,612	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I Date/Time Prepared: 11/25/2014 8:32 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,460,129		1,400,949	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	02/06/2014	42,400		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)		42,400		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)		1,502,529		1,400,949	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		124,592		162,612	6.02
7.00	Total Medicare program liability (see instructions)		1,377,937		1,238,337	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: 151307 | Component CCN: 15Z307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 11/25/2014 8:32 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		853,076		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)		853,076		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		15,849		0	6.02
7.00	Total Medicare program liability (see instructions)		837,227		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151307 Component CCN: 15Z307	Period: From 07/01/2013 To 06/30/2014	Worksheet E-2 Date/Time Prepared: 11/25/2014 8:32 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)	624,938	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)	236,959	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	681	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)	861,897	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	861,897	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)	861,897	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,584	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)	854,313	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)	854,313	0	19.00
19.01	Sequestration adjustment (see instructions)	17,086	0	19.01
20.00	Interim payments	853,076	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	-15,849	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151307	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part V Date/Time Prepared: 11/25/2014 8:32 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,738,310	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)	1,738,310	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,755,693	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,755,693	19.00
20.00	Deductibles (exclude professional component)	357,088	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,398,605	22.00
23.00	Coinsurance	3,312	23.00
24.00	Subtotal (line 22 minus line 23)	1,395,293	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	12,233	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	10,765	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3,024	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,406,058	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)	1,406,058	30.00
30.01	Sequestration adjustment (see instructions)	28,121	30.01
31.00	Interim payments	1,502,529	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	-124,592	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151307	Period: From 07/01/2013 To 06/30/2014	Worksheet E-3 Part VII Date/Time Prepared: 11/25/2014 8:32 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	110,179		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	110,179	0	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)	110,179	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	388,264		8.00
9.00	Ancillary service charges	244,225	0	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)	632,489	0	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)	632,489	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	522,310	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	110,179	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	110,179	0	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)	110,179	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	110,179	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	110,179	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	110,179	0	40.00
41.00	Interim payments	110,179	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G | Date/Time Prepared: 11/25/2014 8:32 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	36,282,542	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,418,568	0	0	0	4.00
5.00	Other receivable	140,316	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,135,329	0	0	0	6.00
7.00	Inventory	319,908	0	0	0	7.00
8.00	Prepaid expenses	184,108	0	0	0	8.00
9.00	Other current assets	-21,254	0	0	0	9.00
10.00	Due from other funds	2,320,536	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	42,509,395	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	174,050	0	0	0	12.00
13.00	Land improvements	106,181	0	0	0	13.00
14.00	Accumulated depreciation	-89,917	0	0	0	14.00
15.00	Buildings	8,329,915	0	0	0	15.00
16.00	Accumulated depreciation	-4,041,923	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	937,049	0	0	0	19.00
20.00	Accumulated depreciation	-632,139	0	0	0	20.00
21.00	Automobiles and trucks	51,450	0	0	0	21.00
22.00	Accumulated depreciation	-51,450	0	0	0	22.00
23.00	Major movable equipment	3,837,214	0	0	0	23.00
24.00	Accumulated depreciation	-3,245,568	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)	5,374,862	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	251,935	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	964,589	434,740	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,216,524	434,740	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	49,100,781	434,740	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	207,376	0	0	0	37.00
38.00	Salaries, wages, and fees payable	679,207	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	58,581	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,980,328	0	0	0	43.00
44.00	Other current liabilities	2,047,195	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,972,687	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	4,035,953	0	0	0	48.00
49.00	Other long term liabilities	96,461	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	4,132,414	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	9,105,101	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	39,995,680				52.00
53.00	Specific purpose fund		434,740			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)	39,995,680	434,740	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	49,100,781	434,740	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-1 | Date/Time Prepared: 11/25/2014 8:32 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		34,941,779		382,371		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,995,892				2.00
3.00	Total (sum of line 1 and line 2)		40,937,671		382,371		3.00
4.00	DEFERRED PENSION COSTS	163,337		0		0	4.00
5.00	GRANT REVENUE	0		52,369		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		163,337		52,369		10.00
11.00	Subtotal (line 3 plus line 10)		41,101,008		434,740		11.00
12.00		0		0		0	12.00
13.00	UNRESTRICTED FUND BALANCE	778		0		0	13.00
14.00	TRANSFER TO RP	1,104,550		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)		1,105,328		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		39,995,680		434,740		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	DEFERRED PENSION COSTS		0		4.00
5.00	GRANT REVENUE		0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00			0		12.00
13.00	UNRESTRICTED FUND BALANCE		0		13.00
14.00	TRANSFER TO RP		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: 151307 | Period: From 07/01/2013 To 06/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/25/2014 8:32 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,805,672		2,805,672	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,805,672		2,805,672	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,805,672		2,805,672	17.00
18.00	Ancillary services	5,020,932	33,653,006	38,673,938	18.00
19.00	Outpatient services	0	12,918,352	12,918,352	19.00
20.00	RURAL HEALTH CLINIC	60,574	2,808,838	2,869,412	20.00
20.01	RURAL HEALTH CLINIC II	98,134	2,449,458	2,547,592	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	104,982	1,562,486	1,667,468	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN PRIVATE OFFICES	828	359,566	360,394	27.00
27.01	ORTHO CLINIC	22,841	1,256,060	1,278,901	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	8,113,963	55,007,766	63,121,729	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,625,507		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		19,625,507		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 151307	Period: From 07/01/2013 To 06/30/2014	Worksheet G-3 Date/Time Prepared: 11/25/2014 8:32 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	63,121,729	1.00
2.00	Less contractual allowances and discounts on patients' accounts	41,761,172	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,360,557	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,625,507	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,735,050	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,420,745	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	7,620	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	AMBULANCE SUBSIDY	308,724	24.00
24.01	CREDENTIALING	6,150	24.01
24.02	PHARMACY SVCS	535	24.02
24.03	RENTAL INCOME - ENT CLINIC	20,700	24.03
24.04	OTHER MISC INCOME	2,850	24.04
24.05	OTHER MISC GRANT REV	9,167	24.05
24.06	OTHER MISC - ORTHO CLINIC	1,782	24.06
24.07	OTHER MISC FOOD SVCS	7,061	24.07
24.08	OTHER MISC - RADIOLOGY	1,763	24.08
24.09	OTHER MISC - NORTH	511	24.09
24.10	OTHER MISC - SOUTH	21,477	24.10
24.12	OTHER MISC - PT	41,820	24.12
25.00	Total other income (sum of lines 6-24)	1,850,905	25.00
26.00	Total (line 5 plus line 25)	3,585,955	26.00
27.00	OTHER MISC - TRANS & STATS	0	27.00
27.01	UNREALIZED INV LOSS	-2,409,937	27.01
27.02		0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	-2,409,937	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,995,892	29.00

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

Provider CCN: 151307 Component CCN: 153993 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 11/25/2014 8:32 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	543,881	0	543,881	0	543,881	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	270,549	0	270,549	0	270,549	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	156,118	0	156,118	0	156,118	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	91,729	0	91,729	0	91,729	9.00
10.00	Subtotal (sum of lines 1-9)	1,062,277	0	1,062,277	0	1,062,277	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	11,530	11,530	0	11,530	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	150,683	150,683	0	150,683	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	162,213	162,213	0	162,213	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,062,277	162,213	1,224,490	0	1,224,490	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	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)	1,062,277	162,213	1,224,490	0	1,224,490	32.00

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

Provider CCN: 151307 | Component CCN: 153993 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 11/25/2014 8:32 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	-35,507	508,374		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	270,549		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	156,118		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	91,729		9.00
10.00	Subtotal (sum of lines 1-9)	-35,507	1,026,770		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	-2,186	9,344		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	150,683		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	-2,186	160,027		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-37,693	1,186,797		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	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)	-37,693	1,186,797		32.00

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

Provider CCN: 151307 Component CCN: 153994 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 11/25/2014 8:32 am

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	606,314	0	606,314	0	606,314	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	90,091	0	90,091	0	90,091	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	212,311	0	212,311	0	212,311	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	209,271	0	209,271	0	209,271	9.00
10.00	Subtotal (sum of lines 1-9)	1,117,987	0	1,117,987	0	1,117,987	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	9,144	9,144	0	9,144	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	122,226	122,226	0	122,226	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	131,370	131,370	0	131,370	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,117,987	131,370	1,249,357	0	1,249,357	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	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)	1,117,987	131,370	1,249,357	0	1,249,357	32.00

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

Provider CCN: 151307 | Component CCN: 153994 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-1 | Date/Time Prepared: 11/25/2014 8:32 am

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-72,456	533,858		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	90,091		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	212,311		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	209,271		9.00
10.00	Subtotal (sum of lines 1-9)	-72,456	1,045,531		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	-2,219	6,925		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	-73	122,153		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	-2,292	129,078		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-74,748	1,174,609		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	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)	-74,748	1,174,609		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 151307 | Component CCN: 153993 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-2 | Date/Time Prepared: 11/25/2014 8:32 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	2.95	12,553	4,200	12,390		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.50	5,231	2,100	3,150		3.00
4.00	Subtotal (sum of lines 1-3)	4.45	17,784		15,540	17,784	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)	4.45	17,784			17,784	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					1,186,797	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)					1,186,797	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)					1,038,042	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,038,042	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					1,038,042	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,038,042	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,224,839	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 151307 | Component CCN: 153994 | Period: From 07/01/2013 To 06/30/2014 | Worksheet M-2 | Date/Time Prepared: 11/25/2014 8:32 am

Rural Health Clinic (RHC) II | 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	2.98	9,438	4,200	12,516		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.50	4,996	2,100	3,150		3.00
4.00	Subtotal (sum of lines 1-3)	4.48	14,434		15,666	15,666	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)	4.48	14,434			15,666	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					1,174,609	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)					1,174,609	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)					1,108,115	15.00
16.00	Total overhead (sum of lines 14 and 15)					1,108,115	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					1,108,115	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					1,108,115	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,282,724	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 151307 Component CCN: 153993	Period: From 07/01/2013 To 06/30/2014	Worksheet M-3 Date/Time Prepared: 11/25/2014 8:32 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)		2,224,839	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)		2,224,839	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		17,784	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		17,784	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		125.10	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	125.10	125.10	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	3,886	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	486,139	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) *		486,139	16.00
16.01	Total program charges (see instructions)(from contractor's records)		572,159	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		43,730	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		37,156	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.)		307,138	16.04
16.05	Total program cost (see instructions)		344,294	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		65,061	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		92,674	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		344,294	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)		344,294	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)		344,294	26.00
26.01	Sequestration adjustment (see instructions)		6,886	26.01
27.00	Interim payments		397,832	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		-60,424	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 151307 Component CCN: 153994	Period: From 07/01/2013 To 06/30/2014	Worksheet M-3 Date/Time Prepared: 11/25/2014 8:32 am
	Title XVIII	Rural Health Clinic (RHC) II	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)		2,282,724	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)		2,282,724	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		15,666	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		15,666	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		145.71	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	145.71	145.71	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	5,162	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	752,155	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) *		752,155	16.00
16.01	Total program charges (see instructions)(from contractor's records)		702,569	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,060	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		3,276	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.)		544,463	16.04
16.05	Total program cost (see instructions)		547,739	16.05
17.00	Primary payer amounts		93	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		68,300	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		126,242	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		547,646	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)		547,646	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)		0	25.00
26.00	Net reimbursable amount (see instructions)		547,646	26.00
26.01	Sequestration adjustment (see instructions)		10,953	26.01
27.00	Interim payments		518,379	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		18,314	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

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

Provider CCN: 151307 Component CCN: 153993

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

Worksheet M-5

Date/Time Prepared: 11/25/2014 8:32 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		397,832	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)		397,832	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		60,424	6.02
7.00	Total Medicare program liability (see instructions)		337,408	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 151307 Component CCN: 153994	Period: From 07/01/2013 To 06/30/2014	Worksheet M-5 Date/Time Prepared: 11/25/2014 8:32 am
		Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		518,379	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)		518,379	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		18,314	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		536,693	7.00

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

Allocation of Physician Compensation: Hours
Department: ANESTHESIA
Physician: AGGREGATE ANESTHESIOLOGY PHYSICIAN

Provider: ST. VINCENT WILLIAMSPORT HOSPITAL
Number: 151307
Specialty: ANESTHESIOLOGY-GENERAL

Basis of Allocation: Time Study **Describe:**

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Heath Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	0.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	0.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	2080.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	2080.00
5. Professional Component Percentage (Line 2 / Line 4)	100.00 %
6. Provider Component Percentage - (Line 1D / Line 4)	0.00 %

Signature: Physician or Physician Department Head Date v7

Allocation of Physician Compensation: Hours
Department: ANESTHESIA
Physician: AGGREGATE RADIOLOGY PHYSICIAN

Provider: ST. VINCENT WILLIAMSPORT HOSPITAL
Number: 151307
Specialty: RADIOLOGY-GENERAL

Basis of Allocation: Time Study **Describe:**

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Heath Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	0.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	0.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	2080.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	2080.00
5. Professional Component Percentage (Line 2 / Line 4)	100.00 %
6. Provider Component Percentage - (Line 1D / Line 4)	0.00 %

Signature: Physician or Physician Department Head Date v7

Allocation of Physician Compensation: Hours
Department: ANESTHESIA
Physician: AGGREGATE EMERGENCY ROOM PHYSICIAN

Provider: ST. VINCENT WILLIAMSPORT HOSPITAL
Number: 151307
Specialty: EMERGENCY MEDICINE-GENERAL

Basis of Allocation: Time Study **Describe:**

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Heath Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	8760.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	8760.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	0.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	8760.00
5. Professional Component Percentage (Line 2 / Line 4)	0.00 %
6. Provider Component Percentage - (Line 1D / Line 4)	100.00 %

Signature: Physician or Physician Department Head Date v7

Allocation of Physician Compensation: Hours
Department: LABORATORY
Physician: AGGREGATE LABORATORY PHYSICIAN

Provider: ST. VINCENT WILLIAMSPORT HOSPITAL
Number: 151307
Specialty: PATHOLOGY-GENERAL

Basis of Allocation: Time Study **Describe:**

Services	Total Hours
1. Provider Services - Teaching and Supervision of I/R's and other GME Related Functions.	0.00
1A. Provider Services - Teaching and Supervision of Allied Heath Students.	0.00
1B. Provider Services - Non Teaching Reimbursable Activities such as Department Administration, Supervision of Nursing, and Technical Staff, Utilization Review, etc.	0.00
1C. Provider Services - Emergency Room Physician Availability (Do not include minimum guarantee arrangements for Emergency Room Physicians.)	0.00
1D. Sub-Total - Provider Administrative Services (Lines 1, 1A, 1B, 1C.)	0.00
2. Physician Services: Medical and Surgical Services to Individual Patients.	2080.00
3. Non-Reimbursable Activities: Research, Teaching of I/R's in Non-Approved Programs, Teaching and Supervision of Medical Students, Writing for Medical Journals, etc.	0.00
4. Total Hours (Lines 1D, 2, and 3)	2080.00
5. Professional Component Percentage (Line 2 / Line 4)	100.00 %
6. Provider Component Percentage - (Line 1D / Line 4)	0.00 %

Signature: Physician or Physician Department Head Date v7