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: 140294	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 6/1/2015 1:13 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 6/1/2015 Time: 1:13 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CROSSROADS COMMUNITY HOSPITAL (140294) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-62,970	-6,619	-64,408	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	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-74,408		0	10.00
10.01	RURAL HEALTH CLINIC II	0		30,037		0	10.01
10.02	RURAL HEALTH CLINIC III	0		3,517		0	10.02
200.00	Total	0	-62,970	-47,473	-64,408	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: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 6/1/2015 12:39 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8 DOCTORS PARK ROAD	PO Box:			1.00
2.00	City: MT VERNON	State: IL	Zip Code: 62864	County: JEFFERSON	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	CROSSROADS COMMUNITY HOSPITAL	140294	99914	1	07/01/1966	N	P	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	CROSSROADS COMMUNITY HOSPITAL	14U294	99914		04/12/1989	N	P	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	CROSSROADS FAMILY MED OF MT. VERNON	148524	99914		07/19/2013	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	CROSSROADS FAMILY MED OF WAYNE CITY	148523	99914		07/19/2013	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	CROSSROADS FAMILY MED OF BENTON	148525	99914		07/19/2013	N	O	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2014	12/31/2014	20.00
21.00	Type of Control (see instructions)	4		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.	Y	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)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	410	135	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 6/1/2015 12:39 pm

		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	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		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.	1		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.	01/01/2014	12/31/2014	38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

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

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

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 6/1/2015 12:39 pm

		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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I | Date/Time Prepared: 6/1/2015 12:39 pm

		1.00	2.00	3.00	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N		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)			106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			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.					109.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part I Date/Time Prepared: 6/1/2015 12:39 pm

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	37,968	837,804	5,000,000	118.01

		1.00	2.00	
		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	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	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: COMMUNITY HEALTH SYSTEM PROFESSIONAL	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140294	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 6/1/2015 12:39 pm

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.50	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2014	09/30/2014	170.00

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II | Date/Time Prepared: 6/1/2015 12:39 pm

		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	04/24/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 6/1/2015 12:39 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				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.	DAVID	LI	41.00
42.00	Enter the employer/company name of the cost report preparer.	CHS		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-465-7764	DAVID_LI@CHS.NET	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-2 Part II Date/Time Prepared: 6/1/2015 12:39 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	04/24/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		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: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I Date/Time Prepared: 6/1/2015 12:39 pm

	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	40	14,600	0.00	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)		40	14,600	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		47	17,155	0.00	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
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		47				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: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 6/1/2015 12:39 pm

	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)	2,141	522	3,233			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,141	522	3,233			7.00
8.00	INTENSIVE CARE UNIT	271	23	489			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)	2,412	545	3,722	0.00	197.58	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	747	0	3,938	0.00	3.00	26.00
26.01	RURAL HEALTH CLINIC II	884	0	3,161	0.00	1.00	26.01
26.02	RURAL HEALTH CLINIC III	263	0	1,184	0.00	2.00	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	203.58	27.00
28.00	Observation Bed Days		0	891			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part I | Date/Time Prepared: 6/1/2015 12:39 pm

	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	713	179	1,175	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	713	179	1,175	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
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 6/1/2015 12:39 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	10,843,771	0	10,843,771	421,184.00	25.75	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		6,240	0	6,240	64.00	97.50	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		326,045	0	326,045	6,334.00	51.48	5.00
6.00	Non-physician-Part B		545,494	0	545,494	20,534.00	26.57	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		47,349	61,232	108,581	3,855.00	28.17	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		159,141	0	159,141	2,672.00	59.56	11.00
12.00	Contract labor: Top level management and other management and administrative services		122,130	0	122,130	1,333.00	91.62	12.00
13.00	Contract labor: Physician-Part A - Administrative		1,003,920	0	1,003,920	8,736.00	114.92	13.00
14.00	Home office salaries & wage-related costs		917,055	0	917,055	15,504.00	59.15	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,097,137	0	3,097,137			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		32,253	0	32,253			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		823	0	823			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		69,866	0	69,866			23.00
24.00	Wage-related costs (RHC/FQHC)		168,455	0	168,455			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	110,122	0	110,122	3,929.00	28.03	26.00
27.00	Administrative & General	5.00	1,546,585	-61,232	1,485,353	53,297.72	27.87	27.00
28.00	Administrative & General under contract (see inst.)		5,772	0	5,772	226.00	25.54	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	148,290	0	148,290	6,268.00	23.66	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	247,938	0	247,938	20,732.35	11.96	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	269,707	-111,062	158,645	11,136.97	14.24	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	111,062	111,062	7,796.54	14.25	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	788,685	0	788,685	20,926.31	37.69	38.00
39.00	Central Services and Supply	14.00	148,718	0	148,718	8,494.45	17.51	39.00
40.00	Pharmacy	15.00	356,746	0	356,746	6,532.00	54.62	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part II Date/Time Prepared: 6/1/2015 12:39 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	268,182	0	268,182	16,171.00	16.58	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part III Date/Time Prepared: 6/1/2015 12:39 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		9,978,004	0	9,978,004	394,542.00	25.29	1.00
2.00	Excluded area salaries (see instructions)		47,349	61,232	108,581	3,855.00	28.17	2.00
3.00	Subtotal salaries (line 1 minus line 2)		9,930,655	-61,232	9,869,423	390,687.00	25.26	3.00
4.00	Subtotal other wages & related costs (see inst.)		2,202,246	0	2,202,246	28,245.00	77.97	4.00
5.00	Subtotal wage-related costs (see inst.)		3,097,960	0	3,097,960	0.00	31.39	5.00
6.00	Total (sum of lines 3 thru 5)		15,230,861	-61,232	15,169,629	418,932.00	36.21	6.00
7.00	Total overhead cost (see instructions)		3,890,745	-61,232	3,829,513	155,510.34	24.63	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part IV Date/Time Prepared: 6/1/2015 12:39 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	161,619	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,827,240	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	23,247	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	11,468	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	-208	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	8,695	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	344,908	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	630,392	17.00
18.00	Medicare Taxes - Employers Portion Only	147,430	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	103,214	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,258,005	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS OTHER BFTS	110,527	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-3 Part V | Date/Time Prepared: 6/1/2015 12:39 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

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

Provider CCN: 140294 Component CCN: 148524 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 | Date/Time Prepared: 6/1/2015 12:39 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	3050 BROADWAY	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	MT.VERNON	IL	62864	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	16:30	08:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, Zip Code, County		JEFFERSON				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	16:30	08:00	16:30	08:00	16:30	11.00

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

Provider CCN: 140294
Component CCN: 148524

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

Worksheet S-8

Date/Time Prepared:
6/1/2015 12:39 pm

Rural Health Clinic (RHC) I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:30				11.00

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

Provider CCN: 140294 Component CCN: 148523 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 | Date/Time Prepared: 6/1/2015 12:39 pm

		Rural Health Clinic (RHC) II	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1209 W ROBINSON	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	WAYNE CITY	IL	62864	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	16:30	08:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, Zip Code, County		WAYNE				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	16:30	08:00	16:30	08:00	12:00	11.00

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

Provider CCN: 140294 | Component CCN: 148523 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 | Date/Time Prepared: 6/1/2015 12:39 pm

Rural Health Clinic (RHC) II | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:30				11.00

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

Provider CCN: 140294 | Component CCN: 148525 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-8 | Date/Time Prepared: 6/1/2015 12:39 pm

		Rural Health Clinic (RHC) III	Cost	
		1.00		
	Clinic Address and Identification			
1.00	Street	905A W. WASHINGTON		1.00
		City	State	Zip Code
		1.00	2.00	3.00
2.00	City, State, Zip Code, County	BENTON	IL	62812 2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	16:30	08:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, Zip Code, County		FRANKLIN				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	16:30	08:00	16:30	08:00	16:30	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 140294 Component CCN: 148525	Period: From 01/01/2014 To 12/31/2014	Worksheet S-8 Date/Time Prepared: 6/1/2015 12:39 pm
		Rural Health Clinic (RHC) III	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:30				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet S-10 | Date/Time Prepared: 6/1/2015 12:39 pm

		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)	0.164279	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,363,391	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	95,546	5.00
6.00	Medicaid charges	42,224,602	6.00
7.00	Medicaid cost (line 1 times line 6)	6,936,615	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)	4,477,678	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	512	9.00
10.00	Stand-alone SCHIP charges	29,966	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	4,923	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	4,411	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)	2,505	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	21,101	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	3,466	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)	961	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,483,050	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	93,954	7,240	101,194	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	15,435	1,189	16,624	21.00
22.00	Partial payment by patients approved for charity care	703	0	703	22.00
23.00	Cost of charity care (line 21 minus line 22)	14,732	1,189	15,921	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)	2,807,973	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	176,953	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,631,020	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	432,221	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	448,142	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4,931,192	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 6/1/2015 12:39 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		781,163	781,163	170,735	951,898	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,185,169	2,185,169	846,048	3,031,217	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	110,122	36,944	147,066	2,444,073	2,591,139	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,546,585	11,673,950	13,220,535	-2,812,536	10,407,999	5.00
7.00	00700	OPERATION OF PLANT	148,290	1,271,403	1,419,693	-26,247	1,393,446	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	107,811	107,811	0	107,811	8.00
9.00	00900	HOUSEKEEPING	247,938	58,492	306,430	0	306,430	9.00
10.00	01000	DIETARY	269,707	190,154	459,861	-190,336	269,525	10.00
11.00	01100	CAFETERIA	0	0	0	189,365	189,365	11.00
13.00	01300	NURSING ADMINISTRATION	788,685	88,561	877,246	-13,932	863,314	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	148,718	1,251,853	1,400,571	-1,048,604	351,967	14.00
15.00	01500	PHARMACY	356,746	654,760	1,011,506	-619,781	391,725	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	268,182	134,948	403,130	-5,564	397,566	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	960,254	627,662	1,587,916	-5,516	1,582,400	30.00
31.00	03100	INTENSIVE CARE UNIT	386,472	89,876	476,348	-4,318	472,030	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,147,908	3,071,778	4,219,686	-1,435,603	2,784,083	50.00
51.00	05100	RECOVERY ROOM	79,603	29,012	108,615	-108,615	0	51.00
53.00	05300	ANESTHESIOLOGY	0	573,597	573,597	0	573,597	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	491,354	865,743	1,357,097	-151,853	1,205,244	54.00
54.01	03630	ULTRA SOUND	113,575	16,638	130,213	0	130,213	54.01
56.00	05600	RADIOISOTOPE	39,954	291,865	331,819	0	331,819	56.00
57.00	05700	CT SCAN	119,742	151,024	270,766	-4,200	266,566	57.00
58.00	05800	MRI	0	107,165	107,165	0	107,165	58.00
60.00	06000	LABORATORY	705,991	548,026	1,254,017	4,922	1,258,939	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	83,120	83,120	-8,506	74,614	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	284,839	69,052	353,891	0	353,891	65.00
66.00	06600	PHYSICAL THERAPY	379,253	214,506	593,759	-115,308	478,451	66.00
67.00	06700	OCCUPATIONAL THERAPY	162,324	20,113	182,437	0	182,437	67.00
68.00	06800	SPEECH PATHOLOGY	74,124	6,503	80,627	0	80,627	68.00
69.00	06900	ELECTROCARDIOLOGY	188,291	22,586	210,877	-276	210,601	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,030,278	1,030,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,174,103	1,174,103	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	568,064	568,064	73.00
74.00	07400	RENAL DIALYSIS	0	22,700	22,700	0	22,700	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	50,328	27,273	77,601	-11,953	65,648	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	392,878	277,219	670,097	-16,732	653,365	88.00
88.01	08801	RURAL HEALTH CLINIC II	173,075	122,075	295,150	-7,247	287,903	88.01
88.02	08802	RURAL HEALTH CLINIC III	305,585	107,026	412,611	-14,495	398,116	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	855,899	1,337,126	2,193,025	-3,645	2,189,380	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,796,422	27,116,893	37,913,315	-177,679	37,735,636	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	178,595	178,595	194.01
194.02	07954	SENIOR CIRCLE	47,349	21,027	68,376	-916	67,460	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	10,843,771	27,137,920	37,981,691	0	37,981,691	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A | Date/Time Prepared: 6/1/2015 12:39 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	90,381	1,042,279		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-522,251	2,508,966		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,256	2,587,883		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,279,315	5,128,684		5.00
7.00	00700	OPERATION OF PLANT	-10,485	1,382,961		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	107,811		8.00
9.00	00900	HOUSEKEEPING	0	306,430		9.00
10.00	01000	DIETARY	0	269,525		10.00
11.00	01100	CAFETERIA	-52,842	136,523		11.00
13.00	01300	NURSING ADMINISTRATION	0	863,314		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	351,967		14.00
15.00	01500	PHARMACY	0	391,725		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-453	397,113		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-438,930	1,143,470		30.00
31.00	03100	INTENSIVE CARE UNIT	0	472,030		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-70,400	2,713,683		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	573,597		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-306,228	899,016		54.00
54.01	03630	ULTRA SOUND	0	130,213		54.01
56.00	05600	RADIOISOTOPE	0	331,819		56.00
57.00	05700	CT SCAN	0	266,566		57.00
58.00	05800	MRI	0	107,165		58.00
60.00	06000	LABORATORY	-12,000	1,246,939		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	74,614		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	-246,299	107,592		65.00
66.00	06600	PHYSICAL THERAPY	0	478,451		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	182,437		67.00
68.00	06800	SPEECH PATHOLOGY	0	80,627		68.00
69.00	06900	ELECTROCARDIOLOGY	0	210,601		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,030,278		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,174,103		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-31	568,033		73.00
74.00	07400	RENAL DIALYSIS	0	22,700		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	65,648		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	30,213	683,578		88.00
88.01	08801	RURAL HEALTH CLINIC II	16,988	304,891		88.01
88.02	08802	RURAL HEALTH CLINIC III	13,251	411,367		88.02
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-70,400	2,118,980		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,862,057	30,873,579		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	MARKETING	0	178,595		194.01
194.02	07954	SENIOR CIRCLE	0	67,460		194.02
194.03	07953	VACANT SPACE	0	0		194.03
194.04	07952	GUEST MEALS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-6,862,057	31,119,634		200.00

RECLASSIFICATIONS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 6/1/2015 12:39 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,446,340		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
	TOTALS		0	2,446,340		
	B - OXYGEN SUPPLY					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	26,247		1.00
	TOTALS		0	26,247		
	C - RENTAL AND LEASE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	843,640		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
18.00		0.00	0	0		18.00
	TOTALS		0	843,640		
	D - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	47,572		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	123,163		2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,408		3.00
	TOTALS		0	173,143		
	E - MARKETING					
1.00	MARKETING	194.01	61,232	117,363		1.00
	TOTALS		61,232	117,363		
	F - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,004,031		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,174,103		2.00
	TOTALS		0	2,178,134		
	G - COST OF DRUGS					
1.00		0.00	0	0		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	568,064		2.00
	TOTALS		0	568,064		
	H - BLOOD AND LAB					
1.00		0.00	0	0		1.00
2.00	LABORATORY	60.00	0	47,901		2.00
3.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	39,395	0		3.00
	TOTALS		39,395	47,901		
	I - MISCELLANEOUS DEPARTMENTS					
1.00	OPERATING ROOM	50.00	79,603	29,012		1.00
	TOTALS		79,603	29,012		
	J - DIETARY					
1.00	CAFETERIA	11.00	111,062	78,303		1.00
	TOTALS		111,062	78,303		
500.00	Grand Total: Increases		291,292	6,508,147		500.00

RECLASSIFICATIONS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-6 | Date/Time Prepared: 6/1/2015 12:39 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,387,623	0		1.00
2.00	OPERATING ROOM	50.00	0	20,243	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	16,732	0		3.00
4.00	RURAL HEALTH CLINIC II	88.01	0	7,247	0		4.00
5.00	RURAL HEALTH CLINIC III	88.02	0	14,495	0		5.00
	TOTALS		0	2,446,340			
	B - OXYGEN SUPPLY						
1.00	OPERATION OF PLANT	7.00	0	26,247	0		1.00
	TOTALS		0	26,247			
	C - RENTAL AND LEASE RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	5,516	10		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	4,318	0		2.00
3.00	ELECTROCARDIOLOGY	69.00	0	276	0		3.00
4.00	OPERATING ROOM	50.00	0	392,182	0		4.00
5.00	PHARMACY	15.00	0	51,717	0		5.00
6.00	LABORATORY	60.00	0	3,584	0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,263	0		7.00
8.00	RADIOLOGY-DIAGNOSTIC	54.00	0	151,853	0		8.00
9.00	CT SCAN	57.00	0	4,200	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	115,308	0		10.00
11.00	EMERGENCY	91.00	0	3,645	0		11.00
12.00	SLEEP LAB	76.01	0	11,953	0		12.00
13.00	ADMINISTRATIVE & GENERAL	5.00	0	73,175	0		13.00
14.00	NURSING ADMINISTRATION	13.00	0	13,932	0		14.00
15.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,267	0		15.00
16.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,564	0		16.00
17.00	SENIOR CIRCLE	194.02	0	916	0		17.00
18.00	DIETARY	10.00	0	971	0		18.00
	TOTALS		0	843,640			
	D - OTHER CAPITAL COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	173,143	12		1.00
2.00		0.00	0	0	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	173,143			
	E - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	61,232	117,363	0		1.00
	TOTALS		61,232	117,363			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,046,341	0		1.00
2.00	OPERATING ROOM	50.00	0	1,131,793	0		2.00
	TOTALS		0	2,178,134			
	G - COST OF DRUGS						
1.00		0.00	0	0	0		1.00
2.00	PHARMACY	15.00	0	568,064	0		2.00
	TOTALS		0	568,064			
	H - BLOOD AND LAB						
1.00		0.00	0	0	0		1.00
2.00	LABORATORY	60.00	39,395	0	0		2.00
3.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	47,901	0		3.00
	TOTALS		39,395	47,901			
	I - MISCELLANEOUS DEPARTMENTS						
1.00	RECOVERY ROOM	51.00	79,603	29,012	0		1.00
	TOTALS		79,603	29,012			
	J - DIETARY						
1.00	DIETARY	10.00	111,062	78,303	0		1.00
	TOTALS		111,062	78,303			
500.00	Grand Total: Decreases		291,292	6,508,147			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part I | Date/Time Prepared: 6/1/2015 12:39 pm

		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	961,157	0	0	0	0	1.00
2.00	Land Improvements	413,167	0	0	0	1,800	2.00
3.00	Buildings and Fixtures	28,731,372	0	0	0	2,668	3.00
4.00	Building Improvements	5,212,416	546,973	0	546,973	0	4.00
5.00	Fixed Equipment	1,539,300	57,485	0	57,485	0	5.00
6.00	Movable Equipment	12,672,729	112,706	0	112,706	126,637	6.00
7.00	HIT designated Assets	4,060,185	749,443	0	749,443	0	7.00
8.00	Subtotal (sum of lines 1-7)	53,590,326	1,466,607	0	1,466,607	131,105	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	53,590,326	1,466,607	0	1,466,607	131,105	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	961,157	0	1.00
2.00	Land Improvements	411,367	0	2.00
3.00	Buildings and Fixtures	28,728,704	0	3.00
4.00	Building Improvements	5,759,389	0	4.00
5.00	Fixed Equipment	1,596,785	0	5.00
6.00	Movable Equipment	12,658,798	0	6.00
7.00	HIT designated Assets	4,809,628	0	7.00
8.00	Subtotal (sum of lines 1-7)	54,925,828	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	54,925,828	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part II | Date/Time Prepared: 6/1/2015 12:39 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	781,163	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,185,169	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,966,332	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	781,163	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,185,169	2.00
3.00	Total (sum of lines 1-2)	0	2,966,332	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-7 Part III Date/Time Prepared: 6/1/2015 12:39 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	35,860,617	0	35,860,617	0.652892	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	19,065,211	0	19,065,211	0.347108	0	2.00
3.00	Total (sum of lines 1-2)	54,925,828	0	54,925,828	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	CAP REL COSTS-BLDG & FIXT	0	0	0	851,233	-150,815	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,549,974	843,640	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,401,207	692,825	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	47,572	123,163	171,126	1,042,279	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	112,944	2,408	0	0	2,508,966	2.00
3.00	Total (sum of lines 1-2)	112,944	49,980	123,163	171,126	3,551,245	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 6/1/2015 12:39 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-91,235	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-11,678	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,144,257			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	662,624			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-52,842	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	A	-31	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-453	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	70,070	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-619,831	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADMIN & GENERAL ORGANIZATION COST	A	-267,300	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8 | Date/Time Prepared: 6/1/2015 12:39 pm

	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	
33.01	BAD DEBTS	A	-3,178,637	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MARKETING EXPENSE	A	-154,003	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	NON-ALLOWABLE LEGAL FEES (DOJ)	A	-405,742	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PHYSICIAN RECRUITING	A	-207,354	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	LOBBYING EXPENSE	A	-11,923	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	CHARITABLE EXPENSE	A	-7,371	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SPECIAL EVENTS	A	-33,844	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MEDICAL STAFF RELATIONS	A	-7,605	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	ILLINOIS PROVIDER TAX	A	-1,210,788	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	GIFT SHOP EXPENSE	A	-4,035	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	NON-ALLOWABLE LEGAL FEES	A	-62,758	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12	VENDING MACHINE	A	-181	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	TELEPHONE BENEFIT COSTS	A	-3,256	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	TELEPHONE DEPRECIATION COST	A	-3,686	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.14
33.15	TELEVISION EXPENSE	A	-10,485	OPERATION OF PLANT	7.00	0	33.15
33.16			0		0.00	0	33.16
33.17	FITNESS REVENUE	B	-590	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.18			0		0.00	0	33.18
33.19	PHOTO COMMISSION	B	-100	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	RURAL HEALTH CLINIC BAD DEBT	A	30,213	RURAL HEALTH CLINIC	88.00	0	33.20
33.21	RENTAL INCOME	B	-150,815	CAP REL COSTS-BLDG & FIXT	1.00	10	33.21
33.22	OTHER MISCELLANEOUS REVENUE	B	-14,403	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	RURAL HEALTH CLINIC II BAD DEBT	A	16,988	RURAL HEALTH CLINIC II	88.01	0	33.23
33.24	RURAL HEALTH CLINIC III BAD DEBT	A	13,251	RURAL HEALTH CLINIC III	88.02	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,862,057				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: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-1 | Date/Time Prepared: 6/1/2015 12:39 pm

	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	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL	141,717	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	DIRECT ALLOCATION - OPERATIN	57,835	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	294,803	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	16,330	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	8,169	0	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	13,079	0	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	104,775	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	796,266	0	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	875,772	232,334	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	184,277	0	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	645,876	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	1,204	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	23,386	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	MIS FEES	0	282,531	4.10
4.11	5.00	ADMINISTRATIVE & GENERAL	MANAGED CARE	0	14,081	4.11
4.12	5.00	ADMINISTRATIVE & GENERAL	CASE MANAGEMENT	0	75,293	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	PURCHASE & ANCILLARY	0	4,330	4.13
4.14	5.00	ADMINISTRATIVE & GENERAL	EMERGENCY ROOM	0	45,040	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	24,022	4.15
4.16	5.00	ADMINISTRATIVE & GENERAL	COMPLIANCE/HIM/CCA FEES	0	20,041	4.16
4.17	5.00	ADMINISTRATIVE & GENERAL	SENIOR CIRCLE	0	12,411	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	356,371	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	22,820	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN UNIT COLLECTION FE	0	70,659	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,493,023	1,830,399	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:					
6.00	B		0.00	CHSPSC	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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.

(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: 140294	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8-1 Date/Time Prepared: 6/1/2015 12:39 pm

	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	141,717	14		1.00
2.00	57,835	0		2.00
3.00	294,803	0		3.00
4.00	16,330	14		4.00
4.01	8,169	11		4.01
4.02	13,079	14		4.02
4.03	104,775	11		4.03
4.04	796,266	0		4.04
4.05	643,438	0		4.05
4.06	184,277	0		4.06
4.07	-645,876	0		4.07
4.08	-1,204	0		4.08
4.09	-23,386	0		4.09
4.10	-282,531	0		4.10
4.11	-14,081	0		4.11
4.12	-75,293	0		4.12
4.13	-4,330	0		4.13
4.14	-45,040	0		4.14
4.15	-24,022	0		4.15
4.16	-20,041	0		4.16
4.17	-12,411	0		4.17
4.18	-356,371	0		4.18
4.19	-22,820	0		4.19
4.20	-70,659	0		4.20
5.00	662,624			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	CHAIN OPERATOR		6.00
7.00	COLLECTION SERV		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet A-8-2 | Date/Time Prepared: 6/1/2015 12:39 pm

	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	DR. A	70,400	70,400	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	60.00	DR. C	12,000	12,000	0	0	0	3.00
4.00	54.00	DR. D	306,228	306,228	0	0	0	4.00
5.00	91.00	DR. E	70,400	70,400	0	0	0	5.00
6.00	30.00	DR. F	438,930	438,930	0	0	0	6.00
7.00	65.00	DR. G	246,299	246,299	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			1,144,257	1,144,257	0		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	DR. A	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	60.00	DR. C	0	0	0	0	0	3.00
4.00	54.00	DR. D	0	0	0	0	0	4.00
5.00	91.00	DR. E	0	0	0	0	0	5.00
6.00	30.00	DR. F	0	0	0	0	0	6.00
7.00	65.00	DR. G	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	DR. A	0	0	0	70,400		1.00
2.00	0.00		0	0	0	0		2.00
3.00	60.00	DR. C	0	0	0	12,000		3.00
4.00	54.00	DR. D	0	0	0	306,228		4.00
5.00	91.00	DR. E	0	0	0	70,400		5.00
6.00	30.00	DR. F	0	0	0	438,930		6.00
7.00	65.00	DR. G	0	0	0	246,299		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	1,144,257		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 6/1/2015 12:39 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,042,279	1,042,279				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,508,966		2,508,966			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,587,883	6,438	15,498	2,609,819		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,128,684	122,949	295,962	361,148	5,908,743	5.00
7.00	00700	OPERATION OF PLANT	1,382,961	196,862	473,888	36,056	2,089,767	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	107,811	4,415	10,627	0	122,853	8.00
9.00	00900	HOUSEKEEPING	306,430	33,191	79,896	60,285	479,802	9.00
10.00	01000	DIETARY	269,525	31,015	74,659	38,574	413,773	10.00
11.00	01100	CAFETERIA	136,523	0	0	27,004	163,527	11.00
13.00	01300	NURSING ADMINISTRATION	863,314	10,269	24,720	191,764	1,090,067	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	351,967	21,930	52,789	36,160	462,846	14.00
15.00	01500	PHARMACY	391,725	8,142	19,599	86,741	506,207	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	397,113	19,946	48,015	65,207	530,281	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,143,470	179,941	433,152	233,480	1,990,043	30.00
31.00	03100	INTENSIVE CARE UNIT	472,030	38,413	92,468	93,968	696,879	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,713,683	123,517	297,329	298,462	3,432,991	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	573,597	1,368	3,292	0	578,257	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	899,016	34,750	83,650	119,470	1,136,886	54.00
54.01	03630	ULTRA SOUND	130,213	4,063	9,780	27,615	171,671	54.01
56.00	05600	RADIOISOTOPE	331,819	3,415	8,221	9,715	353,170	56.00
57.00	05700	CT SCAN	266,566	0	0	29,115	295,681	57.00
58.00	05800	MRI	107,165	0	0	0	107,165	58.00
60.00	06000	LABORATORY	1,246,939	23,889	57,506	162,079	1,490,413	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	74,614	1,216	2,926	9,579	88,335	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	107,592	10,925	26,298	69,257	214,072	65.00
66.00	06600	PHYSICAL THERAPY	478,451	4,399	10,589	92,213	585,652	66.00
67.00	06700	OCCUPATIONAL THERAPY	182,437	0	0	39,468	221,905	67.00
68.00	06800	SPEECH PATHOLOGY	80,627	0	0	18,023	98,650	68.00
69.00	06900	ELECTROCARDIOLOGY	210,601	0	0	45,782	256,383	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,030,278	0	0	0	1,030,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,174,103	0	0	0	1,174,103	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	568,033	0	0	0	568,033	73.00
74.00	07400	RENAL DIALYSIS	22,700	1,863	4,486	0	29,049	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	65,648	13,300	32,016	12,237	123,201	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	683,578	0	0	95,526	779,104	88.00
88.01	08801	RURAL HEALTH CLINIC II	304,891	0	0	42,082	346,973	88.01
88.02	08802	RURAL HEALTH CLINIC III	411,367	0	0	74,301	485,668	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,118,980	50,242	120,941	208,107	2,498,270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,873,579	946,458	2,278,307	2,583,418	30,520,698	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,079	7,412	0	10,491	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,991	7,200	0	10,191	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	178,595	1,640	3,947	14,888	199,070	194.01
194.02	07954	SENIOR CIRCLE	67,460	10,837	26,087	11,513	115,897	194.02
194.03	07953	VACANT SPACE	0	77,274	186,013	0	263,287	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
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)	31,119,634	1,042,279	2,508,966	2,609,819	31,119,634	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I | Date/Time Prepared: 6/1/2015 12:39 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,908,743					5.00
7.00	00700	OPERATION OF PLANT	489,785	2,579,552				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,793	15,904	167,550			8.00
9.00	00900	HOUSEKEEPING	112,453	119,572	4,727	716,554		9.00
10.00	01000	DIETARY	96,977	111,735	1,487	32,758	656,730	10.00
11.00	01100	CAFETERIA	38,326	0	0	0	322,729	11.00
13.00	01300	NURSING ADMINISTRATION	255,482	36,995	0	10,846	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	108,479	79,004	0	23,162	0	14.00
15.00	01500	PHARMACY	118,641	29,331	0	8,599	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	124,284	71,858	0	21,067	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	466,412	648,252	46,246	190,057	271,168	30.00
31.00	03100	INTENSIVE CARE UNIT	163,330	138,386	16,675	40,572	40,516	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	804,591	444,980	32,267	130,459	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	135,528	4,927	0	1,444	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	266,455	125,190	9,680	36,703	0	54.00
54.01	03630	ULTRA SOUND	40,235	14,637	0	4,291	0	54.01
56.00	05600	RADIOISOTOPE	82,774	12,303	0	3,607	0	56.00
57.00	05700	CT SCAN	69,300	0	0	0	0	57.00
58.00	05800	MRI	25,117	0	0	0	0	58.00
60.00	06000	LABORATORY	349,313	86,063	0	25,232	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	20,703	4,379	0	1,284	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	50,173	39,358	4,840	11,539	0	65.00
66.00	06600	PHYSICAL THERAPY	137,261	15,847	0	4,646	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,009	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	23,121	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	60,089	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	241,469	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	275,178	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	133,132	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	6,808	6,713	0	1,968	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	28,875	47,915	0	14,048	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	182,601	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	81,321	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	113,827	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	585,527	181,000	51,628	53,066	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,768,369	2,234,349	167,550	615,348	634,413	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,459	11,093	0	3,252	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,388	10,776	0	3,159	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	46,657	5,907	0	1,732	0	194.01
194.02	07954	SENIOR CIRCLE	27,163	39,041	0	11,446	0	194.02
194.03	07953	VACANT SPACE	61,707	278,386	0	81,617	22,317	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
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)	5,908,743	2,579,552	167,550	716,554	656,730	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 6/1/2015 12:39 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	524,582					11.00
13.00	01300	NURSING ADMINISTRATION	37,204	1,430,594				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14,882	0	688,373			14.00
15.00	01500	PHARMACY	11,161	0	0	673,939		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,764	0	0	0	777,254	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	78,131	293,728	0	0	22,980	30.00
31.00	03100	INTENSIVE CARE UNIT	22,323	118,216	0	0	4,732	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	78,129	375,479	4,211	0	145,166	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	68,618	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,484	150,298	0	0	35,427	54.00
54.01	03630	ULTRA SOUND	7,441	34,741	0	0	11,831	54.01
56.00	05600	RADIOISOTOPE	3,720	12,221	0	0	11,788	56.00
57.00	05700	CT SCAN	11,161	36,627	0	0	109,204	57.00
58.00	05800	MRI	0	0	0	0	10,056	58.00
60.00	06000	LABORATORY	55,807	203,902	0	0	135,174	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,720	12,050	0	0	2,768	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	3,100	64.00
65.00	06500	RESPIRATORY THERAPY	22,323	87,128	0	0	11,138	65.00
66.00	06600	PHYSICAL THERAPY	22,323	0	0	0	12,668	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,441	0	0	0	6,390	67.00
68.00	06800	SPEECH PATHOLOGY	3,720	0	0	0	1,038	68.00
69.00	06900	ELECTROCARDIOLOGY	18,602	57,596	0	0	21,650	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	357,671	0	7,958	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	219,854	0	33,109	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	106,354	673,939	27,612	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	231	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	3,720	15,395	0	0	2,957	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	2,679	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	2,071	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	643	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	52,086	0	0	0	86,266	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	517,142	1,397,381	688,090	673,939	777,254	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	3,720	18,730	283	0	0	194.01
194.02	07954	SENIOR CIRCLE	3,720	14,483	0	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
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)	524,582	1,430,594	688,373	673,939	777,254	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part I Date/Time Prepared: 6/1/2015 12:39 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,007,017	0	4,007,017		30.00
31.00	03100	INTENSIVE CARE UNIT	1,241,629	0	1,241,629		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,448,273	0	5,448,273		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	788,774	0	788,774		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,794,123	0	1,794,123		54.00
54.01	03630	ULTRA SOUND	284,847	0	284,847		54.01
56.00	05600	RADIOISOTOPE	479,583	0	479,583		56.00
57.00	05700	CT SCAN	521,973	0	521,973		57.00
58.00	05800	MRI	142,338	0	142,338		58.00
60.00	06000	LABORATORY	2,345,904	0	2,345,904		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	133,239	0	133,239		62.00
64.00	06400	INTRAVENOUS THERAPY	3,100	0	3,100		64.00
65.00	06500	RESPIRATORY THERAPY	440,571	0	440,571		65.00
66.00	06600	PHYSICAL THERAPY	778,397	0	778,397		66.00
67.00	06700	OCCUPATIONAL THERAPY	287,745	0	287,745		67.00
68.00	06800	SPEECH PATHOLOGY	126,529	0	126,529		68.00
69.00	06900	ELECTROCARDIOLOGY	414,320	0	414,320		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,637,376	0	1,637,376		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,702,244	0	1,702,244		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,509,070	0	1,509,070		73.00
74.00	07400	RENAL DIALYSIS	44,769	0	44,769		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	236,111	0	236,111		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	964,384	0	964,384		88.00
88.01	08801	RURAL HEALTH CLINIC II	430,365	0	430,365		88.01
88.02	08802	RURAL HEALTH CLINIC III	600,138	0	600,138		88.02
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	3,507,843	0	3,507,843		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,870,662	0	29,870,662		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,295	0	27,295		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	26,514	0	26,514		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	276,099	0	276,099		194.01
194.02	07954	SENIOR CIRCLE	211,750	0	211,750		194.02
194.03	07953	VACANT SPACE	707,314	0	707,314		194.03
194.04	07952	GUEST MEALS	0	0	0		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	31,119,634	0	31,119,634		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II Date/Time Prepared: 6/1/2015 12:39 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,438	15,498	21,936	21,936	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	122,949	295,962	418,911	3,031	5.00
7.00	00700	OPERATION OF PLANT	0	196,862	473,888	670,750	303	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,415	10,627	15,042	0	8.00
9.00	00900	HOUSEKEEPING	0	33,191	79,896	113,087	507	9.00
10.00	01000	DIETARY	0	31,015	74,659	105,674	324	10.00
11.00	01100	CAFETERIA	0	0	0	0	227	11.00
13.00	01300	NURSING ADMINISTRATION	0	10,269	24,720	34,989	1,612	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	21,930	52,789	74,719	304	14.00
15.00	01500	PHARMACY	0	8,142	19,599	27,741	729	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,946	48,015	67,961	548	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	179,941	433,152	613,093	1,963	30.00
31.00	03100	INTENSIVE CARE UNIT	0	38,413	92,468	130,881	790	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	123,517	297,329	420,846	2,509	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,368	3,292	4,660	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,750	83,650	118,400	1,004	54.00
54.01	03630	ULTRA SOUND	0	4,063	9,780	13,843	232	54.01
56.00	05600	RADIOISOTOPE	0	3,415	8,221	11,636	82	56.00
57.00	05700	CT SCAN	0	0	0	0	245	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	23,889	57,506	81,395	1,363	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,216	2,926	4,142	81	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	10,925	26,298	37,223	582	65.00
66.00	06600	PHYSICAL THERAPY	0	4,399	10,589	14,988	775	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	332	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	152	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	385	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,863	4,486	6,349	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	13,300	32,016	45,316	103	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	803	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	354	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	625	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	50,242	120,941	171,183	1,749	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	946,458	2,278,307	3,224,765	21,714	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,079	7,412	10,491	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,991	7,200	10,191	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,640	3,947	5,587	125	194.01
194.02	07954	SENIOR CIRCLE	0	10,837	26,087	36,924	97	194.02
194.03	07953	VACANT SPACE	0	77,274	186,013	263,287	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,042,279	2,508,966	3,551,245	21,936	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 6/1/2015 12:39 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	421,942					5.00
7.00	00700	OPERATION OF PLANT	34,974	706,027				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,056	4,353	21,451			8.00
9.00	00900	HOUSEKEEPING	8,030	32,727	605	154,956		9.00
10.00	01000	DIETARY	6,925	30,582	190	7,084	150,779	10.00
11.00	01100	CAFETERIA	2,737	0	0	0	74,095	11.00
13.00	01300	NURSING ADMINISTRATION	18,243	10,126	0	2,346	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,746	21,623	0	5,009	0	14.00
15.00	01500	PHARMACY	8,472	8,028	0	1,860	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,875	19,668	0	4,556	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,305	177,426	5,921	41,099	62,258	30.00
31.00	03100	INTENSIVE CARE UNIT	11,663	37,877	2,135	8,774	9,302	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	57,464	121,792	4,131	28,212	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	9,678	1,349	0	312	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,027	34,265	1,239	7,937	0	54.00
54.01	03630	ULTRA SOUND	2,873	4,006	0	928	0	54.01
56.00	05600	RADIOISOTOPE	5,911	3,367	0	780	0	56.00
57.00	05700	CT SCAN	4,949	0	0	0	0	57.00
58.00	05800	MRI	1,794	0	0	0	0	58.00
60.00	06000	LABORATORY	24,944	23,556	0	5,456	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,478	1,199	0	278	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,583	10,772	620	2,495	0	65.00
66.00	06600	PHYSICAL THERAPY	9,801	4,337	0	1,005	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,714	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,651	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,291	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,243	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,650	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,507	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	486	1,837	0	426	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,062	13,114	0	3,038	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	13,039	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,807	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	8,128	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	41,811	49,540	6,610	11,476	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	411,917	611,544	21,451	133,071	145,655	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	176	3,036	0	703	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	171	2,949	0	683	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	3,332	1,617	0	374	0	194.01
194.02	07954	SENIOR CIRCLE	1,940	10,686	0	2,475	0	194.02
194.03	07953	VACANT SPACE	4,406	76,195	0	17,650	5,124	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
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)	421,942	706,027	21,451	154,956	150,779	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 6/1/2015 12:39 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	77,059					11.00
13.00	01300	NURSING ADMINISTRATION	5,465	72,781				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,186	0	111,587			14.00
15.00	01500	PHARMACY	1,640	0	0	48,470		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,372	0	0	0	105,980	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,473	14,943	0	0	3,134	30.00
31.00	03100	INTENSIVE CARE UNIT	3,279	6,014	0	0	645	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,477	19,103	683	0	19,781	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	9,358	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,919	7,646	0	0	4,831	54.00
54.01	03630	ULTRA SOUND	1,093	1,767	0	0	1,613	54.01
56.00	05600	RADIOISOTOPE	547	622	0	0	1,608	56.00
57.00	05700	CT SCAN	1,640	1,863	0	0	14,893	57.00
58.00	05800	MRI	0	0	0	0	1,371	58.00
60.00	06000	LABORATORY	8,198	10,374	0	0	18,434	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	547	613	0	0	377	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	423	64.00
65.00	06500	RESPIRATORY THERAPY	3,279	4,433	0	0	1,519	65.00
66.00	06600	PHYSICAL THERAPY	3,279	0	0	0	1,728	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,093	0	0	0	871	67.00
68.00	06800	SPEECH PATHOLOGY	547	0	0	0	142	68.00
69.00	06900	ELECTROCARDIOLOGY	2,733	2,930	0	0	2,953	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	57,979	0	1,085	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	35,639	0	4,515	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	17,240	48,470	3,766	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	31	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	547	783	0	0	403	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	365	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	282	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	88	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,651	0	0	0	11,764	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	75,965	71,091	111,541	48,470	105,980	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	547	953	46	0	0	194.01
194.02	07954	SENIOR CIRCLE	547	737	0	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	77,059	72,781	111,587	48,470	105,980	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B Part II | Date/Time Prepared: 6/1/2015 12:39 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	964,615	0	964,615		30.00
31.00	03100	INTENSIVE CARE UNIT	211,360	0	211,360		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	685,998	0	685,998		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	25,357	0	25,357		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	199,268	0	199,268		54.00
54.01	03630	ULTRA SOUND	26,355	0	26,355		54.01
56.00	05600	RADIOISOTOPE	24,553	0	24,553		56.00
57.00	05700	CT SCAN	23,590	0	23,590		57.00
58.00	05800	MRI	3,165	0	3,165		58.00
60.00	06000	LABORATORY	173,720	0	173,720		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,715	0	8,715		62.00
64.00	06400	INTRAVENOUS THERAPY	423	0	423		64.00
65.00	06500	RESPIRATORY THERAPY	64,506	0	64,506		65.00
66.00	06600	PHYSICAL THERAPY	35,913	0	35,913		66.00
67.00	06700	OCCUPATIONAL THERAPY	6,010	0	6,010		67.00
68.00	06800	SPEECH PATHOLOGY	2,492	0	2,492		68.00
69.00	06900	ELECTROCARDIOLOGY	13,292	0	13,292		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,307	0	76,307		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	59,804	0	59,804		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,983	0	78,983		73.00
74.00	07400	RENAL DIALYSIS	9,129	0	9,129		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	65,366	0	65,366		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	14,207	0	14,207		88.00
88.01	08801	RURAL HEALTH CLINIC II	6,443	0	6,443		88.01
88.02	08802	RURAL HEALTH CLINIC III	8,841	0	8,841		88.02
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	301,784	0	301,784		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,090,196	0	3,090,196		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,406	0	14,406		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	13,994	0	13,994		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	12,581	0	12,581		194.01
194.02	07954	SENIOR CIRCLE	53,406	0	53,406		194.02
194.03	07953	VACANT SPACE	366,662	0	366,662		194.03
194.04	07952	GUEST MEALS	0	0	0		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	3,551,245	0	3,551,245		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 6/1/2015 12:39 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS 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	CAP REL COSTS-BLDG & FIXT	130,322					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		130,322				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	805	805	10,733,649			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,373	15,373	1,485,353	-5,908,743	25,210,891	5.00
7.00	00700	OPERATION OF PLANT	24,615	24,615	148,290	0	2,089,767	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	552	0	0	122,853	8.00
9.00	00900	HOUSEKEEPING	4,150	4,150	247,938	0	479,802	9.00
10.00	01000	DIETARY	3,878	3,878	158,645	0	413,773	10.00
11.00	01100	CAFETERIA	0	0	111,062	0	163,527	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	1,284	788,685	0	1,090,067	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	2,742	148,718	0	462,846	14.00
15.00	01500	PHARMACY	1,018	1,018	356,746	0	506,207	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	2,494	268,182	0	530,281	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,499	22,499	960,254	0	1,990,043	30.00
31.00	03100	INTENSIVE CARE UNIT	4,803	4,803	386,472	0	696,879	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,444	15,444	1,227,511	0	3,432,991	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	171	171	0	0	578,257	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	4,345	491,354	0	1,136,886	54.00
54.01	03630	ULTRA SOUND	508	508	113,575	0	171,671	54.01
56.00	05600	RADIOISOTOPE	427	427	39,954	0	353,170	56.00
57.00	05700	CT SCAN	0	0	119,742	0	295,681	57.00
58.00	05800	MRI	0	0	0	0	107,165	58.00
60.00	06000	LABORATORY	2,987	2,987	666,596	0	1,490,413	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	152	39,395	0	88,335	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,366	1,366	284,839	0	214,072	65.00
66.00	06600	PHYSICAL THERAPY	550	550	379,253	0	585,652	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	162,324	0	221,905	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	74,124	0	98,650	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	188,291	0	256,383	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,030,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,174,103	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	568,033	73.00
74.00	07400	RENAL DIALYSIS	233	233	0	0	29,049	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,663	1,663	50,328	0	123,201	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	392,878	0	779,104	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	173,075	0	346,973	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	305,585	0	485,668	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,282	6,282	855,899	0	2,498,270	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	118,341	118,341	10,625,068	-5,908,743	24,611,955	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	385	0	0	10,491	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	374	0	0	10,191	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	205	205	61,232	0	199,070	194.01
194.02	07954	SENIOR CIRCLE	1,355	1,355	47,349	0	115,897	194.02
194.03	07953	VACANT SPACE	9,662	9,662	0	0	263,287	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,042,279	2,508,966	2,609,819		5,908,743	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.997721	19.252053	0.243144		0.234373	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			21,936		421,942	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002044		0.016736	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 6/1/2015 12:39 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	89,529					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	183,667				8.00
9.00	00900	HOUSEKEEPING	4,150	5,182	84,827			9.00
10.00	01000	DIETARY	3,878	1,630	3,878	28,544		10.00
11.00	01100	CAFETERIA	0	0	0	14,027	141	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	0	1,284	0	10	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	0	2,742	0	4	14.00
15.00	01500	PHARMACY	1,018	0	1,018	0	3	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	0	2,494	0	8	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,499	50,694	22,499	11,786	21	30.00
31.00	03100	INTENSIVE CARE UNIT	4,803	18,279	4,803	1,761	6	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,444	35,371	15,444	0	21	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	171	0	171	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	10,611	4,345	0	9	54.00
54.01	03630	ULTRA SOUND	508	0	508	0	2	54.01
56.00	05600	RADIOISOTOPE	427	0	427	0	1	56.00
57.00	05700	CT SCAN	0	0	0	0	3	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,987	0	2,987	0	15	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	0	152	0	1	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,366	5,306	1,366	0	6	65.00
66.00	06600	PHYSICAL THERAPY	550	0	550	0	6	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	2	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	5	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	233	0	233	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,663	0	1,663	0	1	76.01
		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
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,282	56,594	6,282	0	14	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	77,548	183,667	72,846	27,574	139	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	0	385	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	0	374	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	205	0	205	0	1	194.01
194.02	07954	SENIOR CIRCLE	1,355	0	1,355	0	1	194.02
194.03	07953	VACANT SPACE	9,662	0	9,662	970	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
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)	2,579,552	167,550	716,554	656,730	524,582	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.812474	0.912249	8.447240	23.007637	3,720.439716	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	706,027	21,451	154,956	150,779	77,059	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.886015	0.116793	1.826730	5.282336	546.517730	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet B-1 | Date/Time Prepared: 6/1/2015 12:39 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	4,676,892					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,698,366				14.00
15.00	01500	PHARMACY	0	0	568,064			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	181,829,011		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	960,254	0	0	5,375,344		30.00
31.00	03100	INTENSIVE CARE UNIT	386,472	0	0	1,106,829		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,227,511	22,625	0	33,972,399		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,050,911		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	491,354	0	0	8,287,020		54.00
54.01	03630	ULTRA SOUND	113,575	0	0	2,767,421		54.01
56.00	05600	RADIOISOTOPE	39,954	0	0	2,757,456		56.00
57.00	05700	CT SCAN	119,742	0	0	25,544,833		57.00
58.00	05800	MRI	0	0	0	2,352,238		58.00
60.00	06000	LABORATORY	666,596	0	0	31,619,546		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	39,395	0	0	647,434		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	725,165		64.00
65.00	06500	RESPIRATORY THERAPY	284,839	0	0	2,605,273		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,963,389		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,494,736		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	242,888		68.00
69.00	06900	ELECTROCARDIOLOGY	188,291	0	0	5,064,355		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,921,627	0	1,861,571		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,181,192	0	7,744,811		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	571,400	568,064	6,458,882		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	54,000		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	50,328	0	0	691,740		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	626,623		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	484,543		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	150,516		88.02
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0	20,179,088		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,568,311	3,696,844	568,064	181,829,011		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	MARKETING	61,232	1,522	0	0		194.01
194.02	07954	SENIOR CIRCLE	47,349	0	0	0		194.02
194.03	07953	VACANT SPACE	0	0	0	0		194.03
194.04	07952	GUEST MEALS	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,430,594	688,373	673,939	777,254		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.305886	0.186129	1.186379	0.004275		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	72,781	111,587	48,470	105,980		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.015562	0.030172	0.085325	0.000583		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

		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	4,007,017		4,007,017	0	4,007,017	30.00
31.00	03100	INTENSIVE CARE UNIT	1,241,629		1,241,629	0	1,241,629	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,448,273		5,448,273	0	5,448,273	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	788,774		788,774	0	788,774	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,794,123		1,794,123	0	1,794,123	54.00
54.01	03630	ULTRA SOUND	284,847		284,847	0	284,847	54.01
56.00	05600	RADIOISOTOPE	479,583		479,583	0	479,583	56.00
57.00	05700	CT SCAN	521,973		521,973	0	521,973	57.00
58.00	05800	MRI	142,338		142,338	0	142,338	58.00
60.00	06000	LABORATORY	2,345,904		2,345,904	0	2,345,904	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	133,239		133,239	0	133,239	62.00
64.00	06400	INTRAVENOUS THERAPY	3,100		3,100	0	3,100	64.00
65.00	06500	RESPIRATORY THERAPY	440,571	0	440,571	0	440,571	65.00
66.00	06600	PHYSICAL THERAPY	778,397	0	778,397	0	778,397	66.00
67.00	06700	OCCUPATIONAL THERAPY	287,745	0	287,745	0	287,745	67.00
68.00	06800	SPEECH PATHOLOGY	126,529	0	126,529	0	126,529	68.00
69.00	06900	ELECTROCARDIOLOGY	414,320		414,320	0	414,320	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,637,376		1,637,376	0	1,637,376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,702,244		1,702,244	0	1,702,244	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,509,070		1,509,070	0	1,509,070	73.00
74.00	07400	RENAL DIALYSIS	44,769		44,769	0	44,769	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	236,111		236,111	0	236,111	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	964,384		964,384	0	964,384	88.00
88.01	08801	RURAL HEALTH CLINIC II	430,365		430,365	0	430,365	88.01
88.02	08802	RURAL HEALTH CLINIC III	600,138		600,138	0	600,138	88.02
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,507,843		3,507,843	0	3,507,843	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	865,722		865,722		865,722	92.00
200.00		Subtotal (see instructions)	30,736,384	0	30,736,384	0	30,736,384	200.00
201.00		Less Observation Beds	865,722		865,722		865,722	201.00
202.00		Total (see instructions)	29,870,662	0	29,870,662	0	29,870,662	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,255,727		4,255,727			30.00
31.00	03100	INTENSIVE CARE UNIT	1,106,829		1,106,829			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,053,549	25,918,850	33,972,399	0.160374	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	3,872,891	12,178,020	16,050,911	0.049142	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,323,374	6,963,646	8,287,020	0.216498	0.000000	54.00
54.01	03630	ULTRA SOUND	268,932	2,498,489	2,767,421	0.102929	0.000000	54.01
56.00	05600	RADIOISOTOPE	279,761	2,477,695	2,757,456	0.173922	0.000000	56.00
57.00	05700	CT SCAN	4,141,998	21,402,835	25,544,833	0.020434	0.000000	57.00
58.00	05800	MRI	42,671	2,309,567	2,352,238	0.060512	0.000000	58.00
60.00	06000	LABORATORY	6,056,311	25,563,235	31,619,546	0.074192	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	357,925	289,509	647,434	0.205795	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	347,699	377,466	725,165	0.004275	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,853,991	751,282	2,605,273	0.169107	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	709,485	2,253,904	2,963,389	0.262671	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	379,226	1,115,510	1,494,736	0.192506	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,159	218,729	242,888	0.520936	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,273,032	3,791,323	5,064,355	0.081811	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,280,714	580,857	1,861,571	0.879567	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,742,557	2,002,254	7,744,811	0.219792	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,124,109	3,334,773	6,458,882	0.233643	0.000000	73.00
74.00	07400	RENAL DIALYSIS	54,000	0	54,000	0.829056	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	691,740	691,740	0.341329	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	626,623	626,623			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	484,543	484,543			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	150,516	150,516			88.02
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	2,620,495	17,558,593	20,179,088	0.173836	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	279,074	840,543	1,119,617	0.773230	0.000000	92.00
200.00		Subtotal (see instructions)	47,448,509	134,380,502	181,829,011			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	47,448,509	134,380,502	181,829,011			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.160374	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.049142	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216498	54.00
54.01	03630	ULTRA SOUND	0.102929	54.01
56.00	05600	RADIOISOTOPE	0.173922	56.00
57.00	05700	CT SCAN	0.020434	57.00
58.00	05800	MRI	0.060512	58.00
60.00	06000	LABORATORY	0.074192	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.205795	62.00
64.00	06400	INTRAVENOUS THERAPY	0.004275	64.00
65.00	06500	RESPIRATORY THERAPY	0.169107	65.00
66.00	06600	PHYSICAL THERAPY	0.262671	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.192506	67.00
68.00	06800	SPEECH PATHOLOGY	0.520936	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081811	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.879567	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.219792	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233643	73.00
74.00	07400	RENAL DIALYSIS	0.829056	74.00
76.00	03020	ACUPUNCTURE	0.000000	76.00
76.01	03610	SLEEP LAB	0.341329	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.173836	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.773230	92.00
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: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 6/1/2015 12:39 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,007,017		4,007,017	0	4,007,017	30.00
31.00	03100	INTENSIVE CARE UNIT	1,241,629		1,241,629	0	1,241,629	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,448,273		5,448,273	0	5,448,273	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	788,774		788,774	0	788,774	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,794,123		1,794,123	0	1,794,123	54.00
54.01	03630	ULTRA SOUND	284,847		284,847	0	284,847	54.01
56.00	05600	RADIOISOTOPE	479,583		479,583	0	479,583	56.00
57.00	05700	CT SCAN	521,973		521,973	0	521,973	57.00
58.00	05800	MRI	142,338		142,338	0	142,338	58.00
60.00	06000	LABORATORY	2,345,904		2,345,904	0	2,345,904	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	133,239		133,239	0	133,239	62.00
64.00	06400	INTRAVENOUS THERAPY	3,100		3,100	0	3,100	64.00
65.00	06500	RESPIRATORY THERAPY	440,571	0	440,571	0	440,571	65.00
66.00	06600	PHYSICAL THERAPY	778,397	0	778,397	0	778,397	66.00
67.00	06700	OCCUPATIONAL THERAPY	287,745	0	287,745	0	287,745	67.00
68.00	06800	SPEECH PATHOLOGY	126,529	0	126,529	0	126,529	68.00
69.00	06900	ELECTROCARDIOLOGY	414,320		414,320	0	414,320	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,637,376		1,637,376	0	1,637,376	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,702,244		1,702,244	0	1,702,244	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,509,070		1,509,070	0	1,509,070	73.00
74.00	07400	RENAL DIALYSIS	44,769		44,769	0	44,769	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	236,111		236,111	0	236,111	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	964,384		964,384	0	964,384	88.00
88.01	08801	RURAL HEALTH CLINIC II	430,365		430,365	0	430,365	88.01
88.02	08802	RURAL HEALTH CLINIC III	600,138		600,138	0	600,138	88.02
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,507,843		3,507,843	0	3,507,843	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	865,722		865,722		865,722	92.00
200.00		Subtotal (see instructions)	30,736,384	0	30,736,384	0	30,736,384	200.00
201.00		Less Observation Beds	865,722		865,722		865,722	201.00
202.00		Total (see instructions)	29,870,662	0	29,870,662	0	29,870,662	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 6/1/2015 12:39 pm

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	4,255,727		4,255,727			30.00
31.00	03100	INTENSIVE CARE UNIT	1,106,829		1,106,829			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,053,549	25,918,850	33,972,399	0.160374	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	3,872,891	12,178,020	16,050,911	0.049142	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,323,374	6,963,646	8,287,020	0.216498	0.000000	54.00
54.01	03630	ULTRA SOUND	268,932	2,498,489	2,767,421	0.102929	0.000000	54.01
56.00	05600	RADIOISOTOPE	279,761	2,477,695	2,757,456	0.173922	0.000000	56.00
57.00	05700	CT SCAN	4,141,998	21,402,835	25,544,833	0.020434	0.000000	57.00
58.00	05800	MRI	42,671	2,309,567	2,352,238	0.060512	0.000000	58.00
60.00	06000	LABORATORY	6,056,311	25,563,235	31,619,546	0.074192	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	357,925	289,509	647,434	0.205795	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	347,699	377,466	725,165	0.004275	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,853,991	751,282	2,605,273	0.169107	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	709,485	2,253,904	2,963,389	0.262671	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	379,226	1,115,510	1,494,736	0.192506	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,159	218,729	242,888	0.520936	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,273,032	3,791,323	5,064,355	0.081811	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,280,714	580,857	1,861,571	0.879567	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,742,557	2,002,254	7,744,811	0.219792	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,124,109	3,334,773	6,458,882	0.233643	0.000000	73.00
74.00	07400	RENAL DIALYSIS	54,000	0	54,000	0.829056	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	691,740	691,740	0.341329	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	626,623	626,623	1.539018	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	484,543	484,543	0.888187	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	150,516	150,516	3.987204	0.000000	88.02
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	2,620,495	17,558,593	20,179,088	0.173836	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	279,074	840,543	1,119,617	0.773230	0.000000	92.00
200.00		Subtotal (see instructions)	47,448,509	134,380,502	181,829,011			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	47,448,509	134,380,502	181,829,011			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet C Part I Date/Time Prepared: 6/1/2015 12:39 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
		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
88.02	08802	RURAL HEALTH CLINIC III	0.000000		88.02
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part I Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

	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	964,615	0	964,615	4,124	233.90	30.00
31.00	INTENSIVE CARE UNIT	211,360		211,360	489	432.23	31.00
200.00	Total (lines 30-199)	1,175,975		1,175,975	4,613		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	2,141	500,780				30.00
31.00	INTENSIVE CARE UNIT	271	117,134				31.00
200.00	Total (lines 30-199)	2,412	617,914				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part II Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

		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	685,998	33,972,399	0.020193	3,885,789	78,466	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	25,357	16,050,911	0.001580	1,822,527	2,880	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	199,268	8,287,020	0.024046	893,919	21,495	54.00
54.01	03630	ULTRA SOUND	26,355	2,767,421	0.009523	172,349	1,641	54.01
56.00	05600	RADIOISOTOPE	24,553	2,757,456	0.008904	207,173	1,845	56.00
57.00	05700	CT SCAN	23,590	25,544,833	0.000923	2,721,260	2,512	57.00
58.00	05800	MRI	3,165	2,352,238	0.001346	42,671	57	58.00
60.00	06000	LABORATORY	173,720	31,619,546	0.005494	3,934,915	21,618	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,715	647,434	0.013461	224,473	3,022	62.00
64.00	06400	INTRAVENOUS THERAPY	423	725,165	0.000583	204,952	119	64.00
65.00	06500	RESPIRATORY THERAPY	64,506	2,605,273	0.024760	1,125,377	27,864	65.00
66.00	06600	PHYSICAL THERAPY	35,913	2,963,389	0.012119	473,997	5,744	66.00
67.00	06700	OCCUPATIONAL THERAPY	6,010	1,494,736	0.004021	237,818	956	67.00
68.00	06800	SPEECH PATHOLOGY	2,492	242,888	0.010260	19,073	196	68.00
69.00	06900	ELECTROCARDIOLOGY	13,292	5,064,355	0.002625	933,849	2,451	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	76,307	1,861,571	0.040991	892,025	36,565	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	59,804	7,744,811	0.007722	2,715,753	20,971	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,983	6,458,882	0.012229	1,899,549	23,230	73.00
74.00	07400	RENAL DIALYSIS	9,129	54,000	0.169056	32,400	5,477	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	65,366	691,740	0.094495	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,207	626,623	0.022672	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,443	484,543	0.013297	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	8,841	150,516	0.058738	0	0	88.02
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	301,784	20,179,088	0.014955	1,717,713	25,688	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	208,406	1,119,617	0.186140	203,451	37,870	92.00
200.00		Total (lines 50-199)	2,122,627	176,466,455		24,361,033	320,667	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part III Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

		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
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
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	4,124	0.00	2,141	0		30.00
31.00	03100	INTENSIVE CARE UNIT	489	0.00	271	0		31.00
200.00		Total (lines 30-199)	4,613		2,412	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		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
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	33,972,399	0.000000	0.000000	3,885,789	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	16,050,911	0.000000	0.000000	1,822,527	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,287,020	0.000000	0.000000	893,919	54.00
54.01	03630	ULTRA SOUND	0	2,767,421	0.000000	0.000000	172,349	54.01
56.00	05600	RADIOISOTOPE	0	2,757,456	0.000000	0.000000	207,173	56.00
57.00	05700	CT SCAN	0	25,544,833	0.000000	0.000000	2,721,260	57.00
58.00	05800	MRI	0	2,352,238	0.000000	0.000000	42,671	58.00
60.00	06000	LABORATORY	0	31,619,546	0.000000	0.000000	3,934,915	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	647,434	0.000000	0.000000	224,473	62.00
64.00	06400	INTRAVENOUS THERAPY	0	725,165	0.000000	0.000000	204,952	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,605,273	0.000000	0.000000	1,125,377	65.00
66.00	06600	PHYSICAL THERAPY	0	2,963,389	0.000000	0.000000	473,997	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,494,736	0.000000	0.000000	237,818	67.00
68.00	06800	SPEECH PATHOLOGY	0	242,888	0.000000	0.000000	19,073	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,064,355	0.000000	0.000000	933,849	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,861,571	0.000000	0.000000	892,025	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,744,811	0.000000	0.000000	2,715,753	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,458,882	0.000000	0.000000	1,899,549	73.00
74.00	07400	RENAL DIALYSIS	0	54,000	0.000000	0.000000	32,400	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	691,740	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	626,623	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	484,543	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	150,516	0.000000	0.000000	0	88.02
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	20,179,088	0.000000	0.000000	1,717,713	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,119,617	0.000000	0.000000	203,451	92.00
200.00		Total (lines 50-199)	0	176,466,455			24,361,033	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part IV Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,548,094	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	2,916,943	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,097,307	0		54.00
54.01	03630	ULTRA SOUND	0	1,004,383	0		54.01
56.00	05600	RADIOISOTOPE	0	1,146,408	0		56.00
57.00	05700	CT SCAN	0	6,601,073	0		57.00
58.00	05800	MRI	0	612,651	0		58.00
60.00	06000	LABORATORY	0	2,895,057	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	178,965	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	138,625	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	289,325	0		65.00
66.00	06600	PHYSICAL THERAPY	0	329	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	525	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,619,054	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	239,787	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	376,944	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,055,110	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	0	249,480	0		76.01
		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
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	3,804,017	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	277,576	0		92.00
200.00		Total (lines 50-199)	0	32,051,653	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

		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	0.160374	6,548,094	0	0	1,050,144	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.049142	2,916,943	0	0	143,344	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216498	2,097,307	0	0	454,063	54.00
54.01	03630	ULTRA SOUND	0.102929	1,004,383	0	0	103,380	54.01
56.00	05600	RADIOISOTOPE	0.173922	1,146,408	0	0	199,386	56.00
57.00	05700	CT SCAN	0.020434	6,601,073	0	0	134,886	57.00
58.00	05800	MRI	0.060512	612,651	0	0	37,073	58.00
60.00	06000	LABORATORY	0.074192	2,895,057	0	0	214,790	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.205795	178,965	0	0	36,830	62.00
64.00	06400	INTRAVENOUS THERAPY	0.004275	138,625	0	0	593	64.00
65.00	06500	RESPIRATORY THERAPY	0.169107	289,325	0	0	48,927	65.00
66.00	06600	PHYSICAL THERAPY	0.262671	329	0	0	86	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.192506	525	0	0	101	67.00
68.00	06800	SPEECH PATHOLOGY	0.520936	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081811	1,619,054	0	0	132,456	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.879567	239,787	0	0	210,909	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.219792	376,944	0	0	82,849	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233643	1,055,110	0	0	246,519	73.00
74.00	07400	RENAL DIALYSIS	0.829056	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.341329	249,480	0	0	85,155	76.01
		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
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.173836	3,804,017	0	0	661,275	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.773230	277,576	0	0	214,630	92.00
200.00		Subtotal (see instructions)		32,051,653	0	0	4,057,396	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		32,051,653	0	0	4,057,396	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D Part V Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

		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
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
		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
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,124	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,124	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)	3,233	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,141	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,007,017	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,007,017	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)	4,007,017	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)	971.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,080,260	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,080,260	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,241,629	489	2,539.12	271	688,102	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)	4,112,263	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,880,625	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)	617,914	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	320,667	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	938,581	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,942,044	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)	891	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	971.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	865,722	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-1 | Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	964,615	4,007,017	0.240731	865,722	208,406	90.00
91.00	Nursing School cost	0	4,007,017	0.000000	865,722	0	91.00
92.00	Allied health cost	0	4,007,017	0.000000	865,722	0	92.00
93.00	All other Medical Education	0	4,007,017	0.000000	865,722	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet D-3 | Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

		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		2,827,521		30.00
31.00	03100	INTENSIVE CARE UNIT		612,073		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.160374	3,885,789	623,180	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.049142	1,822,527	89,563	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.216498	893,919	193,532	54.00
54.01	03630	ULTRA SOUND	0.102929	172,349	17,740	54.01
56.00	05600	RADIOISOTOPE	0.173922	207,173	36,032	56.00
57.00	05700	CT SCAN	0.020434	2,721,260	55,606	57.00
58.00	05800	MRI	0.060512	42,671	2,582	58.00
60.00	06000	LABORATORY	0.074192	3,934,915	291,939	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.205795	224,473	46,195	62.00
64.00	06400	INTRAVENOUS THERAPY	0.004275	204,952	876	64.00
65.00	06500	RESPIRATORY THERAPY	0.169107	1,125,377	190,309	65.00
66.00	06600	PHYSICAL THERAPY	0.262671	473,997	124,505	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.192506	237,818	45,781	67.00
68.00	06800	SPEECH PATHOLOGY	0.520936	19,073	9,936	68.00
69.00	06900	ELECTROCARDIOLOGY	0.081811	933,849	76,399	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.879567	892,025	784,596	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.219792	2,715,753	596,901	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.233643	1,899,549	443,816	73.00
74.00	07400	RENAL DIALYSIS	0.829056	32,400	26,861	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.341329	0	0	76.01
		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
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.173836	1,717,713	298,600	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.773230	203,451	157,314	92.00
200.00		Total (sum of lines 50-94 and 96-98)		24,361,033	4,112,263	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)		24,361,033		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,982,487		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		994,162		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0		1.04
2.00	Outlier payments for discharges. (see instructions)		86,885		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		250,957		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		44.56		4.00
	Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.70		30.00
31.00	Percentage of Medicaid patient days (see instructions)		14.64		31.00
32.00	Sum of lines 30 and 31		20.34		32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.00		33.00
34.00	Disproportionate share adjustment (see instructions)		59,650		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		9,046,380,143	7,647,644,855	35.00
35.01	Factor 3 (see instructions)		0.000024348	0.000019378	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		220,261	148,196	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		164,743	37,354	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		202,097		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		4,325,281		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		5,740,409		48.00
49.00	Total payment for inpatient operating costs (see instructions)		5,386,627		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		332,732		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		5,719,359		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		5,719,359		61.00
62.00	Deductibles billed to program beneficiaries		638,144		62.00
63.00	Coinsurance billed to program beneficiaries		0		63.00
64.00	Allowable bad debts (see instructions)		140,370		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		91,241		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		99,568		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		5,172,456		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		-239		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-12,845		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-48,140		70.93
70.94	HRR adjustment amount (see instructions)		-932		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part A Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		5,110,300		71.00
71.01	Sequestration adjustment (see instructions)		102,206		71.01
72.00	Interim payments		5,071,064		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-62,970		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		407,609		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	793,829	267,517	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	1.000614	0.997281	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	488	-727	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9882	0.9870	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-9,367	-3,478	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E Part B Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,057,396	2.00
3.00	PPS payments	3,139,896	3.00
4.00	Outlier payment (see instructions)	6,170	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.855	5.00
6.00	Line 2 times line 5	3,469,074	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	90.69	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	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)	3,146,066	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	815	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	723,940	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,421,311	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,421,311	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	2,421,311	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	131,864	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	85,712	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	114,479	36.00
37.00	Subtotal (see instructions)	2,507,023	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,507,023	40.00
40.01	Sequestration adjustment (see instructions)	50,140	40.01
41.00	Interim payments	2,463,502	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-6,619	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: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,071,064		2,463,502	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)		5,071,064		2,463,502	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		62,970		6,619	6.02
7.00	Total Medicare program liability (see instructions)		5,008,094		2,456,883	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: 140294 | Component CCN: 14U294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-1 Part I | Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		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)		0		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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140294	Period: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II Date/Time Prepared: 6/1/2015 12:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,175	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	2,412	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	3,722	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	181,829,011	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	101,194	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	650,086	8.00
9.00	Sequestration adjustment amount (see instructions)	13,002	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	637,084	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	701,492	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-64,408	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 140294 | Component CCN: 14U294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet E-2 | Date/Time Prepared: 6/1/2015 12:39 pm

Title XVIII | Swing Beds - SNF | PPS

		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)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)			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	0	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)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	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)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	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)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
20.00	Interim payments	0	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)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G | Date/Time Prepared: 6/1/2015 12:39 pm

		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	-11,856	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	-5,112,121	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-751,039	0	0	0	6.00
7.00	Inventory	1,547,474	0	0	0	7.00
8.00	Prepaid expenses	270,796	0	0	0	8.00
9.00	Other current assets	138,055	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	-3,918,691	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	961,157	0	0	0	12.00
13.00	Land improvements	411,367	0	0	0	13.00
14.00	Accumulated depreciation	-150,545	0	0	0	14.00
15.00	Buildings	28,729,477	0	0	0	15.00
16.00	Accumulated depreciation	-8,549,341	0	0	0	16.00
17.00	Leasehold improvements	5,659,179	0	0	0	17.00
18.00	Accumulated depreciation	-2,047,443	0	0	0	18.00
19.00	Fixed equipment	1,651,275	0	0	0	19.00
20.00	Accumulated depreciation	-760,214	0	0	0	20.00
21.00	Automobiles and trucks	28,013	0	0	0	21.00
22.00	Accumulated depreciation	-6,502	0	0	0	22.00
23.00	Major movable equipment	10,059,564	0	0	0	23.00
24.00	Accumulated depreciation	-6,481,886	0	0	0	24.00
25.00	Minor equipment depreciable	3,545,682	0	0	0	25.00
26.00	Accumulated depreciation	-1,916,165	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)	31,133,618	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	-1,351,836	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-1,351,836	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,863,091	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,529,324	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,041,820	0	0	0	38.00
39.00	Payroll taxes payable	143,966	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	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	-70,456,528	0	0	0	43.00
44.00	Other current liabilities	156,037	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-67,585,381	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	-67,585,381	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	93,448,472				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	93,448,472	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,863,091	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-1 | Date/Time Prepared: 6/1/2015 12:39 pm

		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		89,153,470		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,295,002				2.00
3.00	Total (sum of line 1 and line 2)		93,448,472		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		93,448,472		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		93,448,472		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 6/1/2015 12:39 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,255,727		4,255,727	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)	4,255,727		4,255,727	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	1,106,829		1,106,829	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)	1,106,829		1,106,829	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,362,556		5,362,556	17.00
18.00	Ancillary services	42,083,253	0	42,083,253	18.00
19.00	Outpatient services	0	133,124,625	133,124,625	19.00
20.00	RURAL HEALTH CLINIC	0	626,623	626,623	20.00
20.01	RURAL HEALTH CLINIC II	0	484,543	484,543	20.01
20.02	RURAL HEALTH CLINIC III	0	150,516	150,516	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	47,445,809	134,386,307	181,832,116	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		37,981,691		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		37,981,691		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140294	Period: From 01/01/2014 To 12/31/2014	Worksheet G-3 Date/Time Prepared: 6/1/2015 12:39 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	181,832,116	1.00
2.00	Less contractual allowances and discounts on patients' accounts	140,524,782	2.00
3.00	Net patient revenues (line 1 minus line 2)	41,307,334	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	37,981,691	4.00
5.00	Net income from service to patients (line 3 minus line 4)	3,325,643	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	969,359	24.00
25.00	Total other income (sum of lines 6-24)	969,359	25.00
26.00	Total (line 5 plus line 25)	4,295,002	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,295,002	29.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B | Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet I-5 | Date/Time Prepared: 6/1/2015 12:39 pm

		1.00	2.00	
	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B			
1.00	Total expenses related to care of program beneficiaries (see instructions)	0		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	0	0	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2.01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions)			2.02
2.03	Total payment due (see instructions)			2.03
2.04	Outlier payments	0		2.04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	0	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3.01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3.02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)			3.03
4.00	Coinsurance billed to Medicare (Part B) patients	0	0	4.00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.01
4.02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4.02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4.03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	0	5.00
5.01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012	0	0	5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013	0	0	5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014	0	0	5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014	0	0	5.04
5.05	Total bad debts (sum of line 5 through line 5.04)	0	0	5.05
6.00	Allowable bad debts (see instructions)	0		6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	8.00
9.00	Program payment (see instructions)	0	0	9.00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11.00
	PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			
12.00	Total allowable expenses (see instructions)	0		12.00
13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)	0		13.00
14.00	Facility specific composite cost percentage (line 13 divided by line 12)	0.000000		14.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140294	Period: From 01/01/2014 To 12/31/2014	Worksheet L Parts I-III Date/Time Prepared: 6/1/2015 12:39 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	313,105	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	19,627	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	10.20	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)	0	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	332,732	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

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

Provider CCN: 140294 Component CCN: 148524 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 6/1/2015 12:39 pm

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	130,781	0	130,781	0	130,781	1.00
2.00	Physician Assistant	145,421	0	145,421	0	145,421	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	71,217	0	71,217	0	71,217	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	37,007	0	37,007	0	37,007	9.00
10.00	Subtotal (sum of lines 1 through 9)	384,426	0	384,426	0	384,426	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	1,064	1,064	0	1,064	15.00
16.00	Transportation (Health Care Staff)	0	957	957	0	957	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,021	2,021	0	2,021	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	384,426	2,021	386,447	0	386,447	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	120,449	120,449	0	120,449	29.00
30.00	Administrative Costs	8,452	154,749	163,201	-16,732	146,469	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	8,452	275,198	283,650	-16,732	266,918	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	392,878	277,219	670,097	-16,732	653,365	32.00

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

Provider CCN: 140294 | Component CCN: 148524 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 6/1/2015 12:39 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	130,781		1.00
2.00	Physician Assistant	0	145,421		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	71,217		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	37,007		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	384,426		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	1,064		15.00
16.00	Transportation (Health Care Staff)	0	957		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	2,021		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	386,447		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	120,449		29.00
30.00	Administrative Costs	30,213	176,682		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	30,213	297,131		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	30,213	683,578		32.00

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

Provider CCN: 140294 Component CCN: 148523 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 6/1/2015 12:39 pm

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	0	0	0	0	0	1.00
2.00	Physician Assistant	112,587	0	112,587	0	112,587	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	31,154	0	31,154	0	31,154	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	25,607	0	25,607	0	25,607	9.00
10.00	Subtotal (sum of lines 1 through 9)	169,348	0	169,348	0	169,348	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	1,453	1,453	0	1,453	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,453	1,453	0	1,453	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	169,348	1,453	170,801	0	170,801	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	46,158	46,158	0	46,158	29.00
30.00	Administrative Costs	3,727	74,464	78,191	-7,247	70,944	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	3,727	120,622	124,349	-7,247	117,102	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	173,075	122,075	295,150	-7,247	287,903	32.00

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

Provider CCN: 140294 | Component CCN: 148523 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 6/1/2015 12:39 pm

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	0	0		1.00
2.00	Physician Assistant	0	112,587		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	31,154		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	25,607		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	169,348		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	1,453		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,453		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	170,801		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	46,158		29.00
30.00	Administrative Costs	16,988	87,932		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	16,988	134,090		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	16,988	304,891		32.00

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

Provider CCN: 140294 Component CCN: 148525 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 6/1/2015 12:39 pm

Rural Health Clinic (RHC) III | 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	197,560	0	197,560	0	197,560	1.00
2.00	Physician Assistant	43,371	0	43,371	0	43,371	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	31,374	0	31,374	0	31,374	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	25,736	0	25,736	0	25,736	9.00
10.00	Subtotal (sum of lines 1 through 9)	298,041	0	298,041	0	298,041	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	1,016	1,016	0	1,016	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,016	1,016	0	1,016	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	298,041	1,016	299,057	0	299,057	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	24,175	24,175	0	24,175	29.00
30.00	Administrative Costs	7,544	81,835	89,379	-14,495	74,884	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	7,544	106,010	113,554	-14,495	99,059	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	305,585	107,026	412,611	-14,495	398,116	32.00

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

Provider CCN: 140294 | Component CCN: 148525 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-1 | Date/Time Prepared: 6/1/2015 12:39 pm

Rural Health Clinic (RHC) III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	197,560		1.00
2.00	Physician Assistant	0	43,371		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	31,374		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	25,736		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	298,041		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	1,016		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,016		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	299,057		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	24,175		29.00
30.00	Administrative Costs	13,251	88,135		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	13,251	112,310		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	13,251	411,367		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-2

Component CCN: 148524 | Date/Time Prepared: 6/1/2015 12:39 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.00	1,461	4,200	4,200		1.00
2.00	Physician Assistant	2.00	2,477	2,100	4,200		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.00	3,938		8,400	8,400	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.00	3,938			8,400	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					386,447	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					386,447	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					297,131	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					280,806	15.00
16.00	Total overhead (sum of lines 14 and 15)					577,937	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					577,937	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					577,937	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					964,384	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140294 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-2

Component CCN: 148523 | Date/Time Prepared: 6/1/2015 12:39 pm

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	0.00	0	0	0		1.00
2.00	Physician Assistant	1.00	3,161	2,100	2,100		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.00	3,161		2,100	3,161	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.00	3,161			3,161	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					170,801	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					170,801	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					134,090	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					125,474	15.00
16.00	Total overhead (sum of lines 14 and 15)					259,564	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					259,564	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					259,564	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					430,365	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140294 | Component CCN: 148525 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-2 | Date/Time Prepared: 6/1/2015 12:39 pm

Rural Health Clinic (RHC) III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.00	398	4,200	4,200		1.00
2.00	Physician Assistant	1.00	786	2,100	2,100		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.00	1,184		6,300	6,300	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.00	1,184			6,300	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					299,057	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					299,057	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					112,310	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					188,771	15.00
16.00	Total overhead (sum of lines 14 and 15)					301,081	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					301,081	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					301,081	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					600,138	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 140294 | Component CCN: 148524 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-3 | Date/Time Prepared: 6/1/2015 12:39 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		964,384	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		534	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		963,850	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		8,400	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		8,400	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		114.74	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	114.74	114.74	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	747	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	85,711	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) *		85,711	16.00
16.01	Total program charges (see instructions)(from contractor's records)		123,123	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		808	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		563	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.)		51,382	16.04
16.05	Total program cost (see instructions)		51,945	16.05
17.00	Primary payer amounts		175	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		20,920	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		20,441	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		51,770	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		534	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		52,304	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			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		52,304	26.00
26.01	Sequestration adjustment (see instructions)		1,046	26.01
27.00	Interim payments		125,666	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)		-74,408	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 140294 | Component CCN: 148523 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-3 | Date/Time Prepared: 6/1/2015 12:39 pm

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 Wkst. M-2, line 20)	430,365	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	11,193	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	419,172	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)	3,161	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	3,161	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	132.61	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	132.61	132.61	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	884	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	117,227	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) *		117,227	16.00
16.01	Total program charges (see instructions)(from contractor's records)		116,618	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		91	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		91	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.)		80,392	16.04
16.05	Total program cost (see instructions)		80,483	16.05
17.00	Primary payer amounts		1,301	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		16,646	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		19,994	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		79,182	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,193	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		90,375	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			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		90,375	26.00
26.01	Sequestration adjustment (see instructions)		1,808	26.01
27.00	Interim payments		58,530	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)		30,037	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 140294 | Component CCN: 148525 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-3 | Date/Time Prepared: 6/1/2015 12:39 pm

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

		1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES		
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)	600,138	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	1,673	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	598,465	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)	6,300	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)	0	5.00
6.00	Total adjusted visits (line 4 plus line 5)	6,300	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	94.99	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	94.99	94.99	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	263	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	24,982	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		24,982	16.00
16.01	Total program charges (see instructions)(from contractor's records)		39,777	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,416	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		889	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.)		16,586	16.04
16.05	Total program cost (see instructions)		17,475	16.05
17.00	Primary payer amounts		11	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		3,360	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		7,283	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		17,464	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,673	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		19,137	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			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		19,137	26.00
26.01	Sequestration adjustment (see instructions)		383	26.01
27.00	Interim payments		15,237	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)		3,517	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 140294 | Component CCN: 148524 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-4 | Date/Time Prepared: 6/1/2015 12:39 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	384,426	384,426	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000500	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	192	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	22	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	214	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	386,447	386,447	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	577,937	577,937	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000554	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	320	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	534	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	2	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	267.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	2	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	534	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		534	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		534	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 140294 | Component CCN: 148523 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-4 | Date/Time Prepared: 6/1/2015 12:39 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	169,348	169,348	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.005000	0.013750	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	847	2,329	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	611	655	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,458	2,984	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	170,801	170,801	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	259,564	259,564	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.008536	0.017471	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,216	4,535	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,674	7,519	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	20	55	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	183.70	136.71	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	20	55	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,674	7,519	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		11,193	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		11,193	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 140294 | Component CCN: 148525 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-4 | Date/Time Prepared: 6/1/2015 12:39 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	298,041	298,041	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000750	0.001500	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	224	447	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	92	71	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	316	518	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	299,057	299,057	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	301,081	301,081	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001057	0.001732	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	318	521	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	634	1,039	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	3	6	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	211.33	173.17	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	3	6	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	634	1,039	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		1,673	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		1,673	16.00

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

Provider CCN: 140294 Component CCN: 148524 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-5 | Date/Time Prepared: 6/1/2015 12:39 pm

Rural Health Clinic (RHC) I | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		45,666	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		07/25/2014	80,000	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)		80,000	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		125,666	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		74,408	6.02
7.00	Total Medicare program liability (see instructions)		51,258	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: 140294 Component CCN: 148523

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

Worksheet M-5

Date/Time Prepared: 6/1/2015 12:39 pm

Rural Health Clinic (RHC) II

Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		58,530	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)		58,530	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		30,037	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		88,567	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: 140294 Component CCN: 148525 | Period: From 01/01/2014 To 12/31/2014 | Worksheet M-5 | Date/Time Prepared: 6/1/2015 12:39 pm

Rural Health Clinic (RHC) III | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		15,237	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)		15,237	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		3,517	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		18,754	7.00

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