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: 141315	Period: From 10/01/2013 To 09/30/2014	Worksheet S Parts I-III Date/Time Prepared: 2/27/2015 2:15 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/27/2015 Time: 2:15 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 BCC DBA ILLINI COMMUNITY HOSPITAL (141315) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	98,230	112,512	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	118,211	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		47,964		0	10.00
200.00	Total	0	216,441	160,476	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2015 2:14 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 640 WEST WASHINGTON	PO Box:			1.00
2.00	City: PITTSFIELD	State: IL	Zip Code: 62363	County: PIKE	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	BCC DBA ILLINI COMMUNITY HOSPITAL	141315	99914	1	09/01/2001	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	BCC DBA ILLINI COMM HOSP-SWINGBED	14Z315	99914		09/01/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	BCC DBA ILLINI COMM HOSP-RHC	143482	99914		07/03/2006	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2013	09/30/2014	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)			22.01
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0		23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2015 2:14 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2015 2:14 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2015 2:14 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2015 2:14 pm

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	101,528	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2015 2:14 pm

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	14H132	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: BLESSING CORPORATE SERVICES	Contractor's Name: NATIONAL GOVERNMENT SERVICES	Contractor's Number: 00131	141.00
142.00	Street: BROADWAY AT 11TH STREET	PO Box:		142.00
143.00	City: QUINCY	State: IL	Zip Code: 62301	143.00

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II | Date/Time Prepared: 2/27/2015 2:14 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)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	12/31/2014	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 2/27/2015 2:14 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				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CONNIE	ZIEGLER	41.00
42.00	Enter the employer/company name of the cost report preparer.	BLESSING CORPORATE SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-223-8400, X4159	CZIEGLER@BLESSINGHOSPITAL.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-2 Part II Date/Time Prepared: 2/27/2015 2:14 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)				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)	12/31/2014			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		DIRECTOR, REVENUE INTEGRITY		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: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2015 2:14 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	25	9,125	20,040.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	20,040.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	20,040.00	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
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2015 2:14 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)	652	51	835			1.00
2.00	HMO and other (see instructions)	67	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	199	0	199			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	3			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	851	51	1,037			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)	851	51	1,037	0.00	140.65	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	2,548	0	9,631	0.00	12.06	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	152.71	27.00
28.00	Observation Bed Days		20	132			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			4			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: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2015 2:14 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	193	22	265	1.00
2.00	HMO and other (see instructions)			19	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	193	22	265	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
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141315 Component CCN: 143482 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-8 | Date/Time Prepared: 2/27/2015 2:14 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	321 WEST WASHINGTON	1.00
	City: 1.00	State: 2.00	Zip Code: 3.00
2.00	City, State, Zip Code, County	PITTSFIELD IL 62363	2.00
			1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0 3.00
		Grant Award: 1.00	Date: 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 1.00	to 2.00	from 3.00	to 4.00	from 5.00
	Facility hours of operations (1)					
11.00	Clinic			07:00	17:30	07:00 11.00

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

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

		Y/N: 1.00	V: 2.00	XVIII: 3.00	XIX: 4.00	Total Visits: 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		PIKE			2.00

		Tuesday: to 6.00	Wednesday: from 7.00	Wednesday: to 8.00	Thursday: from 9.00	Thursday: to 10.00
	Facility hours of operations (1)					
11.00	Clinic	17:30	07:00	17:30	07:00	17:30 11.00

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

Provider CCN: 141315
Component CCN: 143482

Period:
From 10/01/2013
To 09/30/2014

Worksheet S-8

Date/Time Prepared:
2/27/2015 2:14 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	07:00	17:30	07:00	12:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet S-10 | Date/Time Prepared: 2/27/2015 2:14 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)	0.426800	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,249,346	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,920,941	5.00
6.00	Medicaid charges	8,965,529	6.00
7.00	Medicaid cost (line 1 times line 6)	3,826,488	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)	656,201	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	656,201	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	819,167	1,988,756	2,807,923	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	349,620	848,801	1,198,421	21.00
22.00	Partial payment by patients approved for charity care	1,439	1,124	2,563	22.00
23.00	Cost of charity care (line 21 minus line 22)	348,181	847,677	1,195,858	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,381,121	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	538,500	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	842,621	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	359,631	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,555,489	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,211,690	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/27/2015 2:14 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		349,343	349,343	47,815	397,158	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		526,671	526,671	5,085	531,756	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,801,173	2,801,173	0	2,801,173	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,321,592	1,651,281	2,972,873	43,989	3,016,862	5.00
6.00	00600	MAINTENANCE & REPAIRS	331,425	216,159	547,584	0	547,584	6.00
7.00	00700	OPERATION OF PLANT	0	353,228	353,228	67,790	421,018	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	90,698	90,698	0	90,698	8.00
9.00	00900	HOUSEKEEPING	264,027	42,501	306,528	0	306,528	9.00
10.00	01000	DIETARY	198,020	102,776	300,796	0	300,796	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	221,440	39,666	261,106	-121,779	139,327	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,539	204,641	231,180	0	231,180	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	46,612	46,612	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	105,176	105,176	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	842,059	40,846	882,905	-46,615	836,290	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	369,887	149,334	519,221	-1,626	517,595	50.00
53.00	05300	ANESTHESIOLOGY	105,176	8,338	113,514	-113,514	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	675,192	464,095	1,139,287	-15	1,139,272	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	83,901	62,707	146,608	-21,799	124,809	54.01
60.00	06000	LABORATORY	499,225	709,567	1,208,792	-84,621	1,124,171	60.00
65.00	06500	RESPIRATORY THERAPY	125,498	45,992	171,490	-23,179	148,311	65.00
65.01	06501	SLEEP STUDIES	32,107	12,742	44,849	-18	44,831	65.01
66.00	06600	PHYSICAL THERAPY	22,186	28,711	50,897	0	50,897	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,485	124,824	175,309	141,519	316,828	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	310,682	1,461,399	1,772,081	-139	1,771,942	73.00
73.01	03480	ONCOLOGY	130,606	303,867	434,473	-407	434,066	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	547,726	906,385	1,454,111	-19	1,454,092	88.00
91.00	09100	EMERGENCY	738,106	1,937,627	2,675,733	-1,355	2,674,378	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		86,464	86,464	0	86,464	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,895,879	12,721,035	19,616,914	42,900	19,659,814	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	118,849	24,133	142,982	0	142,982	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	0	0	0	0	0	193.02
193.03	19303	LEASED SPACE	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	WELLNESS	112,835	55,885	168,720	-42,900	125,820	193.05
200.00		TOTAL (SUM OF LINES 118-199)	7,127,563	12,801,053	19,928,616	0	19,928,616	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A | Date/Time Prepared: 2/27/2015 2:14 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	0	397,158		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-81,766	449,990		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-481,234	2,319,939		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	868,755	3,885,617		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	547,584		6.00
7.00	00700	OPERATION OF PLANT	-2,819	418,199		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	-486	90,212		8.00
9.00	00900	HOUSEKEEPING	0	306,528		9.00
10.00	01000	DIETARY	-46,371	254,425		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	139,327		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-27,120	204,060		16.00
17.00	01700	SOCIAL SERVICE	0	46,612		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	105,176		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-2,400	833,890		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	517,595		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-20,352	1,118,920		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	124,809		54.01
60.00	06000	LABORATORY	-92,567	1,031,604		60.00
65.00	06500	RESPIRATORY THERAPY	0	148,311		65.00
65.01	06501	SLEEP STUDIES	0	44,831		65.01
66.00	06600	PHYSICAL THERAPY	0	50,897		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-2,261	314,567		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	28,032	1,799,974		73.00
73.01	03480	ONCOLOGY	-292,000	142,066		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-45,757	1,408,335		88.00
91.00	09100	EMERGENCY	-1,379,246	1,295,132		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-86,464	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,664,056	17,995,758		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	142,982		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0		193.01
193.02	19302	RENAL	0	0		193.02
193.03	19303	LEASED SPACE	0	0		193.03
193.04	19304	UNUSED SPACE	0	0		193.04
193.05	19305	WELLNESS	0	125,820		193.05
200.00		TOTAL (SUM OF LINES 118-199)	-1,664,056	18,264,560		200.00

RECLASSIFICATIONS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/27/2015 2:14 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASS PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	10,000		1.00
	TOTALS		0	10,000		
	B - RECLASS UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	67,790		1.00
	TOTALS		0	67,790		
	C - RECLASS MEDICAL SUPPLIES EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	141,519		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
	TOTALS		0	141,519		
	E - RECLASS SOCIAL SERVICE SALARY					
1.00	SOCIAL SERVICE	17.00	46,612	0		1.00
	TOTALS		46,612	0		
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE					
1.00	OPERATING ROOM	50.00	0	7,944		1.00
	TOTALS		0	7,944		
	H - RECLASS CRNA COSTS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	105,176	0		1.00
	TOTALS		105,176	0		
	I - RECLASS UR COORDINATOR SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	32,434	0		1.00
	TOTALS		32,434	0		
	J - RECLASS NURSING MANAGER SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	89,345	0		1.00
	TOTALS		89,345	0		
	K - RECLASS BUILDING RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	42,900		1.00
	TOTALS		0	42,900		
500.00	Grand Total: Increases		273,567	270,153		500.00

RECLASSIFICATIONS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-6 | Date/Time Prepared: 2/27/2015 2:14 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - RECLASS PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	10,000	0	1.00
	TOTALS		0	10,000		
	B - RECLASS UTILITIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	67,790	0	1.00
	TOTALS		0	67,790		
	C - RECLASS MEDICAL SUPPLIES EXPENSE					
1.00	ADULTS & PEDIATRICS	30.00	0	3	0	1.00
2.00	OPERATING ROOM	50.00	0	9,570	0	2.00
3.00	ANESTHESIOLOGY	53.00	0	394	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	15	0	4.00
5.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.01	0	21,799	0	5.00
6.00	LABORATORY	60.00	0	84,621	0	6.00
7.00	RESPIRATORY THERAPY	65.00	0	23,179	0	7.00
8.00	SLEEP STUDIES	65.01	0	18	0	8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	139	0	9.00
10.00	ONCOLOGY	73.01	0	407	0	10.00
11.00	EMERGENCY	91.00	0	1,355	0	11.00
12.00	RURAL HEALTH CLINIC	88.00	0	19	0	12.00
	TOTALS		0	141,519		
	E - RECLASS SOCIAL SERVICE SALARY					
1.00	ADULTS & PEDIATRICS	30.00	46,612	0	0	1.00
	TOTALS		46,612	0		
	F - RECLASS MISCELLANEOUS ANESTH EXPENSE					
1.00	ANESTHESIOLOGY	53.00	0	7,944	0	1.00
	TOTALS		0	7,944		
	H - RECLASS CRNA COSTS					
1.00	ANESTHESIOLOGY	53.00	105,176	0	0	1.00
	TOTALS		105,176	0		
	I - RECLASS UR COORDINATOR SALARY					
1.00	NURSING ADMINISTRATION	13.00	32,434	0	0	1.00
	TOTALS		32,434	0		
	J - RECLASS NURSING MANAGER SALARY					
1.00	NURSING ADMINISTRATION	13.00	89,345	0	0	1.00
	TOTALS		89,345	0		
	K - RECLASS BUILDING RENT					
1.00	WELLNESS	193.05	0	42,900	10	1.00
	TOTALS		0	42,900		
500.00	Grand Total: Decreases		273,567	270,153		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part I | Date/Time Prepared: 2/27/2015 2:14 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	138,751	126,000	0	126,000	0	1.00
2.00	Land Improvements	303,667	66,831	0	66,831	0	2.00
3.00	Buildings and Fixtures	6,493,876	66,990	0	66,990	87,904	3.00
4.00	Building Improvements	942,695	65,754	0	65,754	23,000	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	7,180,132	615,762	0	615,762	79,425	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,059,121	941,337	0	941,337	190,329	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	15,059,121	941,337	0	941,337	190,329	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	264,751	0	1.00
2.00	Land Improvements	370,498	0	2.00
3.00	Buildings and Fixtures	6,472,962	0	3.00
4.00	Building Improvements	985,449	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	7,716,469	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15,810,129	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	15,810,129	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part II | Date/Time Prepared: 2/27/2015 2:14 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	349,343	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	526,671	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	876,014	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	349,343		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	526,671		2.00
3.00	Total (sum of lines 1-2)	0	876,014		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-7 Part III Date/Time Prepared: 2/27/2015 2:14 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	7,458,412	0	7,458,412	0.491497	4,915	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,716,470	0	7,716,470	0.508503	5,085	2.00
3.00	Total (sum of lines 1-2)	15,174,882	0	15,174,882	1.000000	10,000	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	4,915	349,343	42,900	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	5,085	444,905	0	2.00
3.00	Total (sum of lines 1-2)	0	0	10,000	794,248	42,900	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	4,915	0	0	397,158	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5,085	0	0	449,990	2.00
3.00	Total (sum of lines 1-2)	0	10,000	0	0	847,148	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/27/2015 2:14 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)	B	-86,464	INTEREST EXPENSE	113.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,671,246			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	422,925			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,113	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-81,766	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-6,208	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISCELLANEOUS RADIOLOGY INCOME	B	-92	RADIOLOGY-DIAGNOSTIC	54.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8 | Date/Time Prepared: 2/27/2015 2:14 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	
33.02	MISCELLANEOUS SUPPLIES REVENUE	B	-2,261	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	33.02
33.03	CABLE TELEVISION	A	-2,819	OPERATION OF PLANT	7.00	0	33.03
33.04	MISCELLANOUS EXPENSE	A	-24,720	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	PUBLIC RELATIONS SALARIES	A	-32,203	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PUBLIC RELATIONS EMPLOYEE BENEFITS	A	-12,656	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.06
33.07	PUBLIC RELATIONS EXPENSES	A	-81,584	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	COFFEE SHOP RECEIPTS	B	-44,923	DIETARY	10.00	0	33.08
33.09	MEALS ON WHEELS	B	-2,416	DIETARY	10.00	0	33.09
33.10	LOBBYING EXPENSE	A	-10,777	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	NON-RHC PHYSICIAN COST	A	-24,764	RURAL HEALTH CLINIC	88.00	0	33.11
33.12	ACCOUNTING FEES	B	-969	ADMINISTRATIVE & GENERAL	5.00	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,664,056				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: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-1 | Date/Time Prepared: 2/27/2015 2:14 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	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1,129,137	529,291	1.00
2.00	10.00	DIETARY	DIETICIAN	5,233	4,265	2.00
3.00	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY SERVICES	52,946	53,432	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	0	468,578	4.00
4.01	88.00	RURAL HEALTH CLINIC	RHC PHYSICIAN	551,476	559,996	4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	ACCOUNTS PAYABLE COSTS	6,577	9,170	4.02
4.03	88.00	RURAL HEALTH CLINIC	RHC CLINIC BUILDING	8,073	20,546	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	PATIENT FINANCIAL SERVICES	409,976	95,873	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	PATIENT ACCESS	0	11,136	4.05
4.06	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	140,847	166,854	4.06
4.07	54.00	RADIOLOGY-DIAGNOSTIC	ECHO SERVICES	8,240	28,500	4.07
4.08	73.00	DRUGS CHARGED TO PATIENTS	PHARMACY SERVICES	64,032	36,000	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	INFORMATICS	127,746	2,750	4.09
4.10	30.00	ADULTS & PEDIATRICS	CARE MANAGEMENT	0	2,400	4.10
4.11	60.00	LABORATORY	LABORATORY TESTS	51,260	143,827	4.11
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			2,555,543	2,132,618	5.00

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

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

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

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

6.00	B		0.00	BLESSING CORP S	0.00	6.00
7.00	G		0.00	BLESSING HOSP	0.00	7.00
8.00	G		0.00	DENMAN SERVICES	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:	BROTHER/SISTER				100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141315	Period: From 10/01/2013 To 09/30/2014	Worksheet A-8-1 Date/Time Prepared: 2/27/2015 2:14 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	599,846	0		1.00
2.00	968	0		2.00
3.00	-486	0		3.00
4.00	-468,578	0		4.00
4.01	-8,520	0		4.01
4.02	-2,593	0		4.02
4.03	-12,473	0		4.03
4.04	314,103	0		4.04
4.05	-11,136	0		4.05
4.06	-26,007	0		4.06
4.07	-20,260	0		4.07
4.08	28,032	0		4.08
4.09	124,996	0		4.09
4.10	-2,400	0		4.10
4.11	-92,567	0		4.11
5.00	422,925			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			6.00
7.00			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: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-2 | Date/Time Prepared: 2/27/2015 2:14 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	73.01	ONCOLOGY	292,000	292,000	0	0	0	1.00
2.00	91.00	EMERGENCY	1,883,428	1,379,246	504,182	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	1,825	0	1,825	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,177,253	1,671,246	506,007		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	73.01	ONCOLOGY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	73.01	ONCOLOGY	0	0	0	292,000		1.00
2.00	91.00	EMERGENCY	0	0	0	1,379,246		2.00
3.00	13.00	NURSING ADMINISTRATION	0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,671,246		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/27/2015 2:14 pm

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					90	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					78	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					3.45	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	107.35	114.07	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	75.55	56.66	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.78	37.78	28.33			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					8,110	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					6,463	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					14,573	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					14,573	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					65.82	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					51,340	22.00
23.00	Total salary equivalency (see instructions)					51,340	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					3,400	24.00
25.00	Assistants (line 4 times column 3, line 11)					2,210	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					5,610	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					580	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					6,190	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					6,190	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/27/2015 2:14 pm

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	75.55	56.66	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	51,340	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	6,190	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	57,530	63.00
64.00	Total cost of outside supplier services (from your records)	19,056	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	5,610	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	580	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	6,190	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	580	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	580	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/27/2015 2:14 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	397,158	397,158				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	449,990		449,990			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,319,939	0	0	2,319,939		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,885,617	72,862	92,788	461,399	4,512,666	5.00
6.00	00600	MAINTENANCE & REPAIRS	547,584	74,514	94,891	108,365	825,354	6.00
7.00	00700	OPERATION OF PLANT	418,199	0	0	0	418,199	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	90,212	0	0	0	90,212	8.00
9.00	00900	HOUSEKEEPING	306,528	5,782	7,363	86,328	406,001	9.00
10.00	01000	DIETARY	254,425	7,055	8,985	64,746	335,211	10.00
11.00	01100	CAFETERIA	0	2,550	3,248	0	5,798	11.00
13.00	01300	NURSING ADMINISTRATION	139,327	478	608	32,586	172,999	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	204,060	7,549	9,613	8,677	229,899	16.00
17.00	01700	SOCIAL SERVICE	46,612	455	580	15,241	62,888	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	105,176	0	0	34,389	139,565	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	833,890	28,982	36,908	260,084	1,159,864	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	517,595	21,660	27,583	120,940	687,778	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,118,920	14,085	17,937	220,765	1,371,707	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	124,809	1,646	2,096	27,433	155,984	54.01
60.00	06000	LABORATORY	1,031,604	7,855	10,002	163,230	1,212,691	60.00
65.00	06500	RESPIRATORY THERAPY	148,311	2,054	2,615	41,034	194,014	65.00
65.01	06501	SLEEP STUDIES	44,831	841	1,070	10,498	57,240	65.01
66.00	06600	PHYSICAL THERAPY	50,897	10,784	13,733	7,254	82,668	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	314,567	5,865	7,468	16,507	344,407	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,799,974	5,253	6,690	101,582	1,913,499	73.00
73.01	03480	ONCOLOGY	142,066	4,591	5,847	42,704	195,208	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,408,335	0	14,098	179,088	1,601,521	88.00
91.00	09100	EMERGENCY	1,295,132	19,466	24,789	241,336	1,580,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,995,758	294,327	388,912	2,244,186	17,756,096	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,735	2,210	0	3,945	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	142,982	20,997	26,740	38,860	229,579	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	0	7,332	0	0	7,332	193.02
193.03	19303	LEASED SPACE	0	18,931	0	0	18,931	193.03
193.04	19304	UNUSED SPACE	0	28,607	0	0	28,607	193.04
193.05	19305	WELLNESS	125,820	25,229	32,128	36,893	220,070	193.05
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)	18,264,560	397,158	449,990	2,319,939	18,264,560	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/27/2015 2:14 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	4,512,666					5.00
6.00	00600	MAINTENANCE & REPAIRS	270,839	1,096,193				6.00
7.00	00700	OPERATION OF PLANT	137,232	0	555,431			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	29,603	0	0	119,815		8.00
9.00	00900	HOUSEKEEPING	133,229	27,290	13,232	0	579,752	9.00
10.00	01000	DIETARY	109,999	33,301	16,147	0	19,636	10.00
11.00	01100	CAFETERIA	1,903	12,037	5,837	0	7,098	11.00
13.00	01300	NURSING ADMINISTRATION	56,769	2,254	1,093	0	1,329	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	75,441	35,631	17,276	0	21,010	16.00
17.00	01700	SOCIAL SERVICE	20,637	2,149	1,042	0	1,267	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	45,798	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	380,608	136,799	66,327	119,815	80,664	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	225,694	102,233	49,570	0	60,283	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	450,124	66,482	32,236	0	39,202	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	51,186	7,769	3,767	0	4,581	54.01
60.00	06000	LABORATORY	397,943	37,073	17,976	0	21,861	60.00
65.00	06500	RESPIRATORY THERAPY	63,666	9,693	4,700	0	5,715	65.00
65.01	06501	SLEEP STUDIES	18,783	3,967	1,924	0	2,339	65.01
66.00	06600	PHYSICAL THERAPY	27,127	50,899	24,680	0	30,013	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	113,017	27,681	13,422	0	16,322	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	627,908	24,796	12,023	0	14,621	73.00
73.01	03480	ONCOLOGY	64,057	21,670	10,507	0	12,778	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	525,538	52,251	0	0	0	88.00
91.00	09100	EMERGENCY	518,713	91,879	44,550	0	54,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,345,814	745,854	336,309	119,815	392,896	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,295	8,190	3,971	0	4,829	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	75,336	99,107	48,055	0	58,440	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	2,406	34,609	16,781	0	20,407	193.02
193.03	19303	LEASED SPACE	6,212	89,354	27,106	0	32,964	193.03
193.04	19304	UNUSED SPACE	9,387	0	65,470	0	0	193.04
193.05	19305	WELLNESS	72,216	119,079	57,739	0	70,216	193.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,512,666	1,096,193	555,431	119,815	579,752	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I Date/Time Prepared: 2/27/2015 2:14 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	514,294					10.00
11.00	01100	CAFETERIA	0	32,673				11.00
13.00	01300	NURSING ADMINISTRATION	0	666	235,110			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	177	0	379,434		16.00
17.00	01700	SOCIAL SERVICE	0	311	0	0	88,294	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	703	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	514,294	5,313	71,926	19,468	88,294	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,471	30,000	21,227	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,405	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,511	222	121,098	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	561	3,933	10,677	0	54.01
60.00	06000	LABORATORY	0	3,335	0	71,647	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	838	6,475	16,809	0	65.00
65.01	06501	SLEEP STUDIES	0	215	0	2,402	0	65.01
66.00	06600	PHYSICAL THERAPY	0	148	0	1,278	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	337	0	7,145	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,076	0	45,480	0	73.00
73.01	03480	ONCOLOGY	0	873	15,348	3,133	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,659	24,525	0	0	88.00
91.00	09100	EMERGENCY	0	4,931	73,332	57,665	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	514,294	31,125	225,761	379,434	88,294	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	794	9,349	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	0	0	0	0	0	193.02
193.03	19303	LEASED SPACE	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	WELLNESS	0	754	0	0	0	193.05
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)	514,294	32,673	235,110	379,434	88,294	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part I | Date/Time Prepared: 2/27/2015 2:14 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	186,066					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,643,372	0	2,643,372		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,179,256	0	1,179,256		50.00
53.00	05300	ANESTHESIOLOGY	186,066	187,471	0	187,471		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,085,582	0	2,085,582		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	238,458	0	238,458		54.01
60.00	06000	LABORATORY	0	1,762,526	0	1,762,526		60.00
65.00	06500	RESPIRATORY THERAPY	0	301,910	0	301,910		65.00
65.01	06501	SLEEP STUDIES	0	86,870	0	86,870		65.01
66.00	06600	PHYSICAL THERAPY	0	216,813	0	216,813		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	522,331	0	522,331		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,640,403	0	2,640,403		73.00
73.01	03480	ONCOLOGY	0	323,574	0	323,574		73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,207,494	0	2,207,494		88.00
91.00	09100	EMERGENCY	0	2,425,970	0	2,425,970		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	186,066	16,822,030	0	16,822,030		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22,230	0	22,230		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	520,660	0	520,660		192.00
193.00	19300	NONPAID WORKERS	0	0	0	0		193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0		193.01
193.02	19302	RENAL	0	81,535	0	81,535		193.02
193.03	19303	LEASED SPACE	0	174,567	0	174,567		193.03
193.04	19304	UNUSED SPACE	0	103,464	0	103,464		193.04
193.05	19305	WELLNESS	0	540,074	0	540,074		193.05
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	186,066	18,264,560	0	18,264,560		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/27/2015 2:14 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	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	358	72,862	92,788	166,008	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	74,514	94,891	169,405	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	5,782	7,363	13,145	0	9.00
10.00	01000	DIETARY	0	7,055	8,985	16,040	0	10.00
11.00	01100	CAFETERIA	0	2,550	3,248	5,798	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	478	608	1,086	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,549	9,613	17,162	0	16.00
17.00	01700	SOCIAL SERVICE	0	455	580	1,035	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	28,982	36,908	65,890	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	21,660	27,583	49,243	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,085	17,937	32,022	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	1,646	2,096	3,742	0	54.01
60.00	06000	LABORATORY	0	7,855	10,002	17,857	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,054	2,615	4,669	0	65.00
65.01	06501	SLEEP STUDIES	0	841	1,070	1,911	0	65.01
66.00	06600	PHYSICAL THERAPY	0	10,784	13,733	24,517	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,865	7,468	13,333	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,253	6,690	11,943	0	73.00
73.01	03480	ONCOLOGY	0	4,591	5,847	10,438	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	14,098	14,098	0	88.00
91.00	09100	EMERGENCY	0	19,466	24,789	44,255	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	358	294,327	388,912	683,597	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,735	2,210	3,945	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	20,997	26,740	47,737	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	0	7,332	0	7,332	0	193.02
193.03	19303	LEASED SPACE	0	18,931	0	18,931	0	193.03
193.04	19304	UNUSED SPACE	0	28,607	0	28,607	0	193.04
193.05	19305	WELLNESS	0	25,229	32,128	57,357	0	193.05
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)	358	397,158	449,990	847,506	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/27/2015 2:14 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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	166,008					5.00
6.00	00600	MAINTENANCE & REPAIRS	9,964	179,369				6.00
7.00	00700	OPERATION OF PLANT	5,048	0	5,048			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,089	0	0	1,089		8.00
9.00	00900	HOUSEKEEPING	4,901	4,465	120	0	22,631	9.00
10.00	01000	DIETARY	4,047	5,449	147	0	767	10.00
11.00	01100	CAFETERIA	70	1,970	53	0	277	11.00
13.00	01300	NURSING ADMINISTRATION	2,088	369	10	0	52	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,775	5,830	157	0	820	16.00
17.00	01700	SOCIAL SERVICE	759	352	9	0	49	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,685	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,002	22,385	604	1,089	3,148	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,303	16,728	451	0	2,353	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,559	10,878	293	0	1,530	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	1,883	1,271	34	0	179	54.01
60.00	06000	LABORATORY	14,640	6,066	163	0	853	60.00
65.00	06500	RESPIRATORY THERAPY	2,342	1,586	43	0	223	65.00
65.01	06501	SLEEP STUDIES	691	649	17	0	91	65.01
66.00	06600	PHYSICAL THERAPY	998	8,329	224	0	1,172	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,158	4,529	122	0	637	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,094	4,057	109	0	571	73.00
73.01	03480	ONCOLOGY	2,357	3,546	95	0	499	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	19,334	8,550	0	0	0	88.00
91.00	09100	EMERGENCY	19,082	15,034	405	0	2,115	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	159,869	122,043	3,056	1,089	15,336	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	48	1,340	36	0	189	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,771	16,217	437	0	2,281	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	89	5,663	153	0	797	193.02
193.03	19303	LEASED SPACE	229	14,621	246	0	1,287	193.03
193.04	19304	UNUSED SPACE	345	0	595	0	0	193.04
193.05	19305	WELLNESS	2,657	19,485	525	0	2,741	193.05
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)	166,008	179,369	5,048	1,089	22,631	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II Date/Time Prepared: 2/27/2015 2:14 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	26,450					10.00
11.00	01100	CAFETERIA	0	8,168				11.00
13.00	01300	NURSING ADMINISTRATION	0	166	3,771			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	44	0	26,788		16.00
17.00	01700	SOCIAL SERVICE	0	78	0	0	2,282	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	176	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,450	1,328	1,153	1,374	2,282	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	618	481	1,498	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	99	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,128	4	8,561	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	140	63	753	0	54.01
60.00	06000	LABORATORY	0	834	0	5,055	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	210	104	1,186	0	65.00
65.01	06501	SLEEP STUDIES	0	54	0	169	0	65.01
66.00	06600	PHYSICAL THERAPY	0	37	0	90	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	84	0	504	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	519	0	3,209	0	73.00
73.01	03480	ONCOLOGY	0	218	246	221	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	915	393	0	0	88.00
91.00	09100	EMERGENCY	0	1,233	1,177	4,069	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	26,450	7,782	3,621	26,788	2,282	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	198	150	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	0	0	0	0	0	193.02
193.03	19303	LEASED SPACE	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	WELLNESS	0	188	0	0	0	193.05
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)	26,450	8,168	3,771	26,788	2,282	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B Part II | Date/Time Prepared: 2/27/2015 2:14 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,861					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		139,705	0	139,705		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		79,675	0	79,675		50.00
53.00	05300	ANESTHESIOLOGY		99	0	99		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		70,975	0	70,975		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC		8,065	0	8,065		54.01
60.00	06000	LABORATORY		45,468	0	45,468		60.00
65.00	06500	RESPIRATORY THERAPY		10,363	0	10,363		65.00
65.01	06501	SLEEP STUDIES		3,582	0	3,582		65.01
66.00	06600	PHYSICAL THERAPY		35,367	0	35,367		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		23,367	0	23,367		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		43,502	0	43,502		73.00
73.01	03480	ONCOLOGY		17,620	0	17,620		73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		43,290	0	43,290		88.00
91.00	09100	EMERGENCY		87,370	0	87,370		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	608,448	0	608,448		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		5,558	0	5,558		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		69,791	0	69,791		192.00
193.00	19300	NONPAID WORKERS		0	0	0		193.00
193.01	19301	AUTOMATED HEALTH SERVICES		0	0	0		193.01
193.02	19302	RENAL		14,034	0	14,034		193.02
193.03	19303	LEASED SPACE		35,314	0	35,314		193.03
193.04	19304	UNUSED SPACE		29,547	0	29,547		193.04
193.05	19305	WELLNESS		82,953	0	82,953		193.05
200.00		Cross Foot Adjustments	1,861	1,861	0	1,861		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,861	847,506	0	847,506		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/27/2015 2:14 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	124,742					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		110,985				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	7,095,360			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,885	22,885	1,411,168	-4,512,666	13,751,894	5.00
6.00	00600	MAINTENANCE & REPAIRS	23,404	23,404	331,425	0	825,354	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	418,199	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	90,212	8.00
9.00	00900	HOUSEKEEPING	1,816	1,816	264,027	0	406,001	9.00
10.00	01000	DIETARY	2,216	2,216	198,020	0	335,211	10.00
11.00	01100	CAFETERIA	801	801	0	0	5,798	11.00
13.00	01300	NURSING ADMINISTRATION	150	150	99,661	0	172,999	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,371	2,371	26,539	0	229,899	16.00
17.00	01700	SOCIAL SERVICE	143	143	46,612	0	62,888	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	105,176	0	139,565	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,103	9,103	795,447	0	1,159,864	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,803	6,803	369,887	0	687,778	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,424	4,424	675,192	0	1,371,707	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	517	517	83,901	0	155,984	54.01
60.00	06000	LABORATORY	2,467	2,467	499,225	0	1,212,691	60.00
65.00	06500	RESPIRATORY THERAPY	645	645	125,498	0	194,014	65.00
65.01	06501	SLEEP STUDIES	264	264	32,107	0	57,240	65.01
66.00	06600	PHYSICAL THERAPY	3,387	3,387	22,186	0	82,668	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,842	1,842	50,485	0	344,407	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,650	1,650	310,682	0	1,913,499	73.00
73.01	03480	ONCOLOGY	1,442	1,442	130,606	0	195,208	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,477	547,726	0	1,601,521	88.00
91.00	09100	EMERGENCY	6,114	6,114	738,106	0	1,580,723	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	92,444	95,921	6,863,676	-4,512,666	13,243,430	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	545	545	0	0	3,945	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,595	6,595	118,849	0	229,579	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	2,303	0	0	0	7,332	193.02
193.03	19303	LEASED SPACE	5,946	0	0	0	18,931	193.03
193.04	19304	UNUSED SPACE	8,985	0	0	0	28,607	193.04
193.05	19305	WELLNESS	7,924	7,924	112,835	0	220,070	193.05
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)	397,158	449,990	2,319,939		4,512,666	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.183835	4.054512	0.326966		0.328149	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		166,008	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.012072	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/27/2015 2:14 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			6.00	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						5.00
6.00	00600	MAINTENANCE & REPAIRS	72,945					6.00
7.00	00700	OPERATION OF PLANT	0	76,227				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,037			8.00
9.00	00900	HOUSEKEEPING	1,816	1,816	0	65,426		9.00
10.00	01000	DIETARY	2,216	2,216	0	2,216	1,037	10.00
11.00	01100	CAFETERIA	801	801	0	801	0	11.00
13.00	01300	NURSING ADMINISTRATION	150	150	0	150	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,371	2,371	0	2,371	0	16.00
17.00	01700	SOCIAL SERVICE	143	143	0	143	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,103	9,103	1,037	9,103	1,037	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,803	6,803	0	6,803	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,424	4,424	0	4,424	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	517	517	0	517	0	54.01
60.00	06000	LABORATORY	2,467	2,467	0	2,467	0	60.00
65.00	06500	RESPIRATORY THERAPY	645	645	0	645	0	65.00
65.01	06501	SLEEP STUDIES	264	264	0	264	0	65.01
66.00	06600	PHYSICAL THERAPY	3,387	3,387	0	3,387	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,842	1,842	0	1,842	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,650	1,650	0	1,650	0	73.00
73.01	03480	ONCOLOGY	1,442	1,442	0	1,442	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,477	0	0	0	0	88.00
91.00	09100	EMERGENCY	6,114	6,114	0	6,114	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,632	46,155	1,037	44,339	1,037	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	545	545	0	545	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,595	6,595	0	6,595	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	2,303	2,303	0	2,303	0	193.02
193.03	19303	LEASED SPACE	5,946	3,720	0	3,720	0	193.03
193.04	19304	UNUSED SPACE	0	8,985	0	0	0	193.04
193.05	19305	WELLNESS	7,924	7,924	0	7,924	0	193.05
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)	1,096,193	555,431	119,815	579,752	514,294	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.027665	7.286539	115.540019	8.861187	495.944069	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	179,369	5,048	1,089	22,631	26,450	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.458962	0.066223	1.050145	0.345902	25.506268	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet B-1 | Date/Time Prepared: 2/27/2015 2:14 pm

		Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NURSING SALARIES)	MEDICAL RECORDS & LIBRARY (TOTAL CHARGES)	SOCIAL SERVICE (PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	16.00	17.00	19.00	
		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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	4,890,720					11.00
13.00	01300	NURSING ADMINISTRATION	99,661	1,886,952				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	26,539	0	37,445,435			16.00
17.00	01700	SOCIAL SERVICE	46,612	0	0	1,037		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	105,176	0	0	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	795,447	577,267	1,921,294	1,037		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	369,887	240,775	2,094,870	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	138,647	0	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	675,192	1,778	11,950,802	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	83,901	31,566	1,053,731	0	0	54.01
60.00	06000	LABORATORY	499,225	0	7,070,613	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	125,498	51,964	1,658,827	0	0	65.00
65.01	06501	SLEEP STUDIES	32,107	0	237,060	0	0	65.01
66.00	06600	PHYSICAL THERAPY	22,186	0	126,132	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	50,485	0	705,141	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	310,682	0	4,488,335	0	0	73.00
73.01	03480	ONCOLOGY	130,606	123,178	309,217	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	547,726	196,837	0	0	0	88.00
91.00	09100	EMERGENCY	738,106	588,557	5,690,766	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,659,036	1,811,922	37,445,435	1,037	100	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	118,849	75,030	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	AUTOMATED HEALTH SERVICES	0	0	0	0	0	193.01
193.02	19302	RENAL	0	0	0	0	0	193.02
193.03	19303	LEASED SPACE	0	0	0	0	0	193.03
193.04	19304	UNUSED SPACE	0	0	0	0	0	193.04
193.05	19305	WELLNESS	112,835	0	0	0	0	193.05
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)	32,673	235,110	379,434	88,294	186,066	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.006681	0.124598	0.010133	85.143684	1,860.660000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,168	3,771	26,788	2,282	1,861	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001670	0.001998	0.000715	2.200579	18.610000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,643,372		2,643,372	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,179,256		1,179,256	0	0	50.00
53.00	05300	ANESTHESIOLOGY	187,471		187,471	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,085,582		2,085,582	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	238,458		238,458	0	0	54.01
60.00	06000	LABORATORY	1,762,526		1,762,526	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	301,910	0	301,910	0	0	65.00
65.01	06501	SLEEP STUDIES	86,870	0	86,870	0	0	65.01
66.00	06600	PHYSICAL THERAPY	216,813	0	216,813	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	522,331		522,331	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,640,403		2,640,403	0	0	73.00
73.01	03480	ONCOLOGY	323,574		323,574	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,207,494		2,207,494	0	0	88.00
91.00	09100	EMERGENCY	2,425,970		2,425,970	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	299,207		299,207		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	17,121,237	0	17,121,237	0	0	200.00
201.00		Less Observation Beds	299,207		299,207		0	201.00
202.00		Total (see instructions)	16,822,030	0	16,822,030	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,420,602		1,420,602			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,619	2,081,251	2,094,870	0.562926	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	138,647	138,647	1.352146	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	313,991	11,636,811	11,950,802	0.174514	0.000000	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	3,892	1,049,839	1,053,731	0.226299	0.000000	54.01
60.00	06000	LABORATORY	353,493	6,717,120	7,070,613	0.249275	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	333,907	1,324,920	1,658,827	0.182002	0.000000	65.00
65.01	06501	SLEEP STUDIES	0	237,060	237,060	0.366447	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	99,280	26,852	126,132	1.718937	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	60,999	644,142	705,141	0.740747	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	523,922	3,964,413	4,488,335	0.588281	0.000000	73.00
73.01	03480	ONCOLOGY	0	309,217	309,217	1.046430	0.000000	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,968,891	1,968,891			88.00
91.00	09100	EMERGENCY	5,329	5,685,437	5,690,766	0.426299	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	500,692	500,692	0.597587	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,129,034	36,285,292	39,414,326			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,129,034	36,285,292	39,414,326			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet C Part I Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.000000		54.01
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
65.01	06501	SLEEP STUDIES	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	03480	ONCOLOGY	0.000000		73.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part II Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	79,675	2,094,870	0.038033	13,618	518	50.00
53.00	05300	ANESTHESIOLOGY	99	138,647	0.000714	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	70,975	11,950,802	0.005939	234,351	1,392	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	8,065	1,053,731	0.007654	3,892	30	54.01
60.00	06000	LABORATORY	45,468	7,070,613	0.006431	264,067	1,698	60.00
65.00	06500	RESPIRATORY THERAPY	10,363	1,658,827	0.006247	265,035	1,656	65.00
65.01	06501	SLEEP STUDIES	3,582	237,060	0.015110	0	0	65.01
66.00	06600	PHYSICAL THERAPY	35,367	126,132	0.280397	21,560	6,045	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,367	705,141	0.033138	48,680	1,613	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	43,502	4,488,335	0.009692	364,243	3,530	73.00
73.01	03480	ONCOLOGY	17,620	309,217	0.056983	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	43,290	1,968,891	0.021987	0	0	88.00
91.00	09100	EMERGENCY	87,370	5,690,766	0.015353	4,416	68	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	19,070	500,692	0.038087	0	0	92.00
200.00		Total (lines 50-199)	487,813	37,993,724		1,219,862	16,550	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	186,066	0	0	0	186,066	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	03480	ONCOLOGY	0	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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)	186,066	0	0	0	186,066	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,094,870	0.000000	0.000000	13,618	50.00
53.00	05300	ANESTHESIOLOGY	0	138,647	1.342012	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,950,802	0.000000	0.000000	234,351	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	1,053,731	0.000000	0.000000	3,892	54.01
60.00	06000	LABORATORY	0	7,070,613	0.000000	0.000000	264,067	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,658,827	0.000000	0.000000	265,035	65.00
65.01	06501	SLEEP STUDIES	0	237,060	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	126,132	0.000000	0.000000	21,560	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	705,141	0.000000	0.000000	48,680	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,488,335	0.000000	0.000000	364,243	73.00
73.01	03480	ONCOLOGY	0	309,217	0.000000	0.000000	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,968,891	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	5,690,766	0.000000	0.000000	4,416	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	500,692	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	37,993,724			1,219,862	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part IV | Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0		54.01
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
65.01	06501	SLEEP STUDIES	0	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01	03480	ONCOLOGY	0	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.562926	0	1,057,659	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.352146	0	33,891	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174514	0	4,837,915	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.226299	0	651,284	0	0	54.01
60.00	06000	LABORATORY	0.249275	0	2,918,451	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.182002	0	779,809	0	0	65.00
65.01	06501	SLEEP STUDIES	0.366447	0	83,045	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1.718937	0	12,664	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.740747	0	322,481	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.588281	0	2,348,690	0	0	73.00
73.01	03480	ONCOLOGY	1.046430	0	179,620	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.426299	0	1,928,110	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.597587	0	305,356	0	0	92.00
200.00		Subtotal (see instructions)		0	15,458,975	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	15,458,975	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	595,384	0		50.00
53.00	05300	ANESTHESIOLOGY	45,826	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	844,284	0		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	147,385	0		54.01
60.00	06000	LABORATORY	727,497	0		60.00
65.00	06500	RESPIRATORY THERAPY	141,927	0		65.00
65.01	06501	SLEEP STUDIES	30,432	0		65.01
66.00	06600	PHYSICAL THERAPY	21,769	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	238,877	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,381,690	0		73.00
73.01	03480	ONCOLOGY	187,960	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	821,951	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	182,477	0		92.00
200.00		Subtotal (see instructions)	5,367,459	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,367,459	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141315 | Component CCN: 14Z315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V | Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.562926	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.352146	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174514	0	0	0	0	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.226299	0	0	0	0	54.01
60.00	06000	LABORATORY	0.249275	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.182002	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0.366447	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1.718937	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.740747	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.588281	0	0	0	0	73.00
73.01	03480	ONCOLOGY	1.046430	0	0	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.426299	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.597587	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141315 | Component CCN: 14Z315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D Part V | Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0	0		54.01
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	06501	SLEEP STUDIES	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	03480	ONCOLOGY	0	0		73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,169	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	967	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)	835	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	50	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)	149	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	1	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)	2	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	652	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)	50	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)	149	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	124.69	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	126.77	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,643,372	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)	125	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)	254	25.00
26.00	Total swing-bed cost (see instructions)	451,456	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,191,916	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,191,916	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)	2,266.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,477,901	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,477,901	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	452,787	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,930,688	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	113,336	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	337,741	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	451,077	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)	132	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,266.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	299,207	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-1 | Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	139,705	2,191,916	0.063736	299,207	19,070	90.00
91.00	Nursing School cost	0	2,191,916	0.000000	299,207	0	91.00
92.00	Allied health cost	0	2,191,916	0.000000	299,207	0	92.00
93.00	All other Medical Education	0	2,191,916	0.000000	299,207	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3 | Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,028,531		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.562926	13,618	7,666	50.00
53.00	05300	ANESTHESIOLOGY	1.352146	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174514	234,351	40,898	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.226299	3,892	881	54.01
60.00	06000	LABORATORY	0.249275	264,067	65,825	60.00
65.00	06500	RESPIRATORY THERAPY	0.182002	265,035	48,237	65.00
65.01	06501	SLEEP STUDIES	0.366447	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1.718937	21,560	37,060	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.740747	48,680	36,060	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.588281	364,243	214,277	73.00
73.01	03480	ONCOLOGY	1.046430	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.426299	4,416	1,883	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.597587	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,219,862	452,787	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,219,862		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet D-3

Component CCN: 14Z315 | Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.562926	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1.352146	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.174514	6,799	1,187	54.00
54.01	03450	NUCLEAR MEDICINE - DIAGNOSTIC	0.226299	0	0	54.01
60.00	06000	LABORATORY	0.249275	21,426	5,341	60.00
65.00	06500	RESPIRATORY THERAPY	0.182002	15,587	2,837	65.00
65.01	06501	SLEEP STUDIES	0.366447	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1.718937	69,545	119,543	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.740747	9,958	7,376	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.588281	51,701	30,415	73.00
73.01	03480	ONCOLOGY	1.046430	0	0	73.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.426299	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.597587	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		175,016	166,699	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)		175,016		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141315	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 2/27/2015 2:14 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,367,459	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,367,459	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR 413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,421,134	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	36,611	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,514,319	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	2,870,204	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,870,204	30.00
31.00	Primary payer payments	100	31.00
32.00	Subtotal (line 30 minus line 31)	2,870,104	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Worksheet I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	677,269	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	514,724	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	675,755	36.00
37.00	Subtotal (see instructions)	3,384,828	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,384,828	40.00
40.01	Sequestration adjustment (see instructions)	67,697	40.01
41.00	Interim payments	3,204,619	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	112,512	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: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2015 2:14 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,400,161		3,377,303	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	05/30/2014	229,313		0	3.01
3.02		09/25/2014	57,663		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	05/30/2014	172,684	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)		286,976		-172,684	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,687,137		3,204,619	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		98,230		112,512	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,785,367		3,317,131	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: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2015 2:14 pm

Component CCN: 14Z315 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		398,915		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	05/30/2014	52,900		0	3.01
3.02		09/25/2014	39,516		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)		92,416		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)		491,331		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		118,211		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		609,542		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141315 Component CCN: 14Z315	Period: From 10/01/2013 To 09/30/2014	Worksheet E-2 Date/Time Prepared: 2/27/2015 2:14 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	455,588	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, column 3, line 200 for Part A, and sum of Wkst. D, Part V, columns 6 and 7, line 202 for Part B) (For CAH, see instructions)	168,366	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	199	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)	623,954	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	623,954	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)	623,954	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	1,972	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	621,982	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	RURAL DEMONSTRATION PROJECT	0		16.50
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	621,982	0	19.00
19.01	Sequestration adjustment (see instructions)	12,440	0	19.01
20.00	Interim payments	491,331	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	118,211	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141315	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part V Date/Time Prepared: 2/27/2015 2:14 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,930,688	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 thru 3)	1,930,688	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,949,995	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,949,995	19.00
20.00	Deductibles (exclude professional component)	151,968	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,798,027	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,798,027	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	31,284	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	23,776	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	31,284	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,821,803	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (line 28, plus or minus lines 29)	1,821,803	30.00
30.01	Sequestration adjustment (see instructions)	36,436	30.01
31.00	Interim payments	1,687,137	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program line 30 minus lines 30.01, 31, and 32	98,230	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G | Date/Time Prepared: 2/27/2015 2:14 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	7,361,343	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,656,127	0	0	0	4.00
5.00	Other receivable	-742,816	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,468,364	0	0	0	6.00
7.00	Inventory	465,737	0	0	0	7.00
8.00	Prepaid expenses	112,332	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	10,384,359	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	264,751	0	0	0	12.00
13.00	Land improvements	370,497	0	0	0	13.00
14.00	Accumulated depreciation	-272,176	0	0	0	14.00
15.00	Buildings	8,627,988	0	0	0	15.00
16.00	Accumulated depreciation	-4,160,095	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	7,716,470	0	0	0	23.00
24.00	Accumulated depreciation	-5,868,614	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	6,678,821	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	54,134	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	54,134	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	17,117,314	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	804,162	0	0	0	37.00
38.00	Salaries, wages, and fees payable	842,474	0	0	0	38.00
39.00	Payroll taxes payable	30,179	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	336,164	0	0	0	43.00
44.00	Other current liabilities	1,696,697	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,709,676	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	3,506,125	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	76,979	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	3,583,104	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	7,292,780	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	9,824,534				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)	9,824,534	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	17,117,314	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-1 | Date/Time Prepared: 2/27/2015 2:14 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		9,096,943		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		510,183				2.00
3.00	Total (sum of line 1 and line 2)		9,607,126		0		3.00
4.00	RELEASED FROM RESTRICTIONS	531,811		0		0	4.00
5.00	CONTRIBUTIONS	290,447		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)		822,258		0		10.00
11.00	Subtotal (line 3 plus line 10)		10,429,384		0		11.00
12.00	RELEASED FROM RESTRICTIONS	600,313		0		0	12.00
13.00	OTHER	4,537		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)		604,850		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,824,534		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	RELEASED FROM RESTRICTIONS		0		4.00
5.00	CONTRIBUTIONS		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	RELEASED FROM RESTRICTIONS		0		12.00
13.00	OTHER		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: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/27/2015 2:14 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,295,328		1,295,328	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	129,876		129,876	5.00
6.00	Swing bed - NF	1,958		1,958	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)	1,427,162		1,427,162	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,427,162		1,427,162	17.00
18.00	Ancillary services	1,823,988	0	1,823,988	18.00
19.00	Outpatient services	0	38,180,335	38,180,335	19.00
20.00	RURAL HEALTH CLINIC	0	1,968,891	1,968,891	20.00
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)	3,251,150	40,149,226	43,400,376	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		19,928,616		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)		19,928,616		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141315 | Period: From 10/01/2013 To 09/30/2014 | Worksheet G-3 | Date/Time Prepared: 2/27/2015 2:14 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	43,400,376	1.00
2.00	Less contractual allowances and discounts on patients' accounts	23,474,104	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,926,272	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,928,616	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-2,344	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	104,630	6.00
7.00	Income from investments	12,187	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	47,338	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	120,047	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	228,325	24.00
25.00	Total other income (sum of lines 6-24)	512,527	25.00
26.00	Total (line 5 plus line 25)	510,183	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)	510,183	29.00

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

Provider CCN: 141315 | Component CCN: 143482 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/27/2015 2:14 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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	153,137	0	153,137	0	153,137	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	261,963	0	261,963	0	261,963	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	3,935	0	3,935	0	3,935	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1-9)	419,035	0	419,035	0	419,035	10.00
11.00	Physician Services Under Agreement	0	559,996	559,996	0	559,996	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	257,417	257,417	0	257,417	13.00
14.00	Subtotal (sum of lines 11-13)	0	817,413	817,413	0	817,413	14.00
15.00	Medical Supplies	0	19	19	-19	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	20,503	20,503	0	20,503	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15-20)	0	20,522	20,522	-19	20,503	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	419,035	837,935	1,256,970	-19	1,256,951	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	33,947	33,947	0	33,947	29.00
30.00	Administrative Costs	128,691	34,503	163,194	0	163,194	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	128,691	68,450	197,141	0	197,141	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	547,726	906,385	1,454,111	-19	1,454,092	32.00

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

Provider CCN: 141315 | Component CCN: 143482 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-1 | Date/Time Prepared: 2/27/2015 2:14 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	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	153,137		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	261,963		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	3,935		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1-9)	0	419,035		10.00
11.00	Physician Services Under Agreement	-33,284	526,712		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	257,417		13.00
14.00	Subtotal (sum of lines 11-13)	-33,284	784,129		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	20,503		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15-20)	0	20,503		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-33,284	1,223,667		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-12,473	21,474		29.00
30.00	Administrative Costs	0	163,194		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-12,473	184,668		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-45,757	1,408,335		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141315 | Component CCN: 143482 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-2 | Date/Time Prepared: 2/27/2015 2:14 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	1.72	6,841	4,200	7,224		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.43	2,790	2,100	3,003		3.00
4.00	Subtotal (sum of lines 1-3)	3.15	9,631		10,227	10,227	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4-7)	3.15	9,631			10,227	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Worksheet M-1, column 7, line 22)					1,223,667	10.00
11.00	Total nonreimbursable costs (from Worksheet M-1, column 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,223,667	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Worksheet M-1, column 7, line 31)					184,668	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					799,159	15.00
16.00	Total overhead (sum of lines 14 and 15)					983,827	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtract line 17 from line 16					983,827	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					983,827	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,207,494	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141315 | Component CCN: 143482 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-3 | Date/Time Prepared: 2/27/2015 2:14 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 Worksheet M-2, line 20)		2,207,494	1.00
2.00	Cost of vaccines and their administration (from Worksheet M-4, line 15)		6,500	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,200,994	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		10,227	4.00
5.00	Physicians visits under agreement (from Worksheet M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		10,227	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		215.21	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.17	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	215.21	215.21	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	653	1,895	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	140,532	407,823	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) *		548,355	16.00
16.01	Total program charges (see instructions)(from contractor's records)		458,455	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		590	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		706	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.)		417,839	16.04
16.05	Total program cost (see instructions)		418,545	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		25,350	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		86,621	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		418,545	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		12,660	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		431,205	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
26.00	Net reimbursable amount (see instructions)		431,205	26.00
26.01	Sequestration adjustment (see instructions)		8,624	26.01
27.00	Interim payments		374,617	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		47,964	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, section 115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141315 | Component CCN: 143482 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-4 | Date/Time Prepared: 2/27/2015 2:14 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Worksheet M-1, column 7, line 10)	419,035	419,035	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000087	0.002246	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	36	941	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,046	1,580	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,082	2,521	5.00
6.00	Total direct cost of the facility (from Worksheet M-1, column 7, line 22)	1,223,667	1,223,667	6.00
7.00	Total overhead (from Worksheet M-2, line 16)	983,827	983,827	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000884	0.002060	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	870	2,027	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,952	4,548	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	8	162	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	244.00	28.07	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	13	338	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,172	9,488	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 10) (transfer this amount to Worksheet M-3, line 2)		6,500	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of columns 1 and 2, line 14) (transfer this amount to Worksheet M-3, line 21)		12,660	16.00

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

Provider CCN: 141315 Component CCN: 143482 | Period: From 10/01/2013 To 09/30/2014 | Worksheet M-5 | Date/Time Prepared: 2/27/2015 2:14 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		359,869	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		05/30/2014	7,148	3.01
3.02		09/25/2014	7,600	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)		14,748	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		374,617	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		47,964	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		422,581	7.00

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