

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 10/01/2012 To 09/30/2013 Worksheet 5 Parts I-III Date/Time Prepared: 2/28/2014 1:56 pm

PART I - COST REPORT STATUS

Provider use only 1. [X] Electronically filed cost report Date: 2/28/2014 Time: 1:56 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 6. Date Received: 10. NPR Date:
(1) As Submitted 7. Contractor No. 11. Contractor's Vendor Code: 4
(2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Enter
(3) Settled with Audit 9. [N] Final Report for this Provider CCN number of times reopened = 0-9.
(4) Reopened
(5) Amended

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 10/01/2012 and ending 09/30/2013 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.

Encryption Information

ECR: Date: 2/28/2014 Time: 1:56 pm
FoTzgf1sBCLoINH5sEGeWmuHfprkm0
ChJt00Ij.801zib9zfjWtd6wpzVMW4
Dnv20k0Jwj0Airos
PI: Date: 2/28/2014 Time: 1:56 pm
0:pd1U0jilMPDmLkxbJB3MLIiUgdC0
DJlXB0aQMfv0u9c:wgyS24pvcjvjox
GZKD0EBVzL0iadct

(Signed) _____ officer or Administrator of Provider(s)
Title _____
Date _____

Table with columns: Title V (1.00), Title XVI (Part A 2.00, Part B 3.00), Title XVII (4.00), Title XVIII (5.00), and Title XIX (1.00). Rows include Hospital, Subprovider - IPF, Subprovider - IRF, Swing bed - SNF, Swing bed - NF, RURAL HEALTH CLINIC I, and Total.

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-2
Part I
Date/Time Prepared:
2/28/2014 1:51 pm

		1.00	2.00	3.00	4.00						
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 640 WEST WASHINGTON	PO Box:		Zip Code: 62363		County: PIKE					1.00
2.00	City: PITTSFIELD	State: IL									2.00
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, 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	142315	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 OLTG										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:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2012	09/30/2013				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
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		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	0		0		25.00
						Urban/Rural S	Date of Geogr				
						1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					2					26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					2					27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0					35.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141315	Period: From 10/01/2012 To 09/30/2013	Worksheet S-2 Part I Date/Time Prepared: 2/28/2014 1:51 pm		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N				39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete worksheet E-4. If column 2 is "N", complete worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete worksheet D-5.					58.00
59.00	Are costs claimed on line 100 of worksheet A? If yes, complete worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.20
		1.00				
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00
				Unweighted FTEs in Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))
		1.00	2.00	3.00	4.00	5.00
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
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))
		1.00	2.00	3.00	4.00	5.00
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000 66.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs In Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	67.00	
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				N	70.00	
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	71.00	
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				N	75.00	
76.00	If line 75 yes: column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)				0	76.00	
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.				N	80.00	
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(1) TEFRA? Enter "Y" for yes or "N" for no.				N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00	
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title v and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.				N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.				N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.				N	N	93.00
94.00	Does title v or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.				N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.				N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
Rural Providers							
105.00	Does this hospital qualify as a critical Access Hospital (CAH)?				Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				N		106.00

		V	XIX			
		1.00	2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	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 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
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

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		1.00	2.00	3.00				
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.								
141.00	Name: 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 5413.13)								
155.00	Hospital	N	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00	
161.00	CMHC		N	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)						0.00	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

		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)	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
		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
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	12/31/2013	Y
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
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
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

	Description	Part A		Part B	
		Y/N	Date	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		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		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		N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		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		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		N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		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.	Y		Y	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		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		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		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		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		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		N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		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

		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)	12/31/2013		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 OF 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

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet S-2
Part IX
Date/Time Prepared:
2/28/2014 1:51 pm

		Title V 1.00	Title XIX 2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE				
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on w/s B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on w/s C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on w/s D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient 1.00	Outpatient 2.00	
CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V 1.00	Title XIX 2.00	
RCE DISALLOWANCE				
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on w/s C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

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	25,680.00	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	25,680.00	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	25,680.00	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 10/01/2012
To 09/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
2/28/2014 1:51 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)		879	65	1,070			1.00
2.00 HMO and other (see instructions)		32	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		190	0	190			5.00
6.00 Hospital Adults & Peds. Swing Bed NF			0	4			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		1,069	65	1,264			7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	1,069		65	1,264	0.00	144.81	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	1,787		0	7,405	0.00	9.98	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00 Total (sum of lines 14-26)					0.00	154.79	27.00
28.00 Observation Bed Days			10	103			28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)				1			30.00
31.00 Employee discount days - IRF				0			31.00
32.00 Labor & delivery days (see instructions)			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 10/01/2012
To 09/30/2013

Worksheet S-3
Part 1
Date/Time Prepared:
2/28/2014 1:51 pm

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)			0	241	23	306	1.00
2.00 HMO and other (see instructions)					7		2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	241		23	306	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 10/01/2012 To 09/30/2013	Worksheet S-8 Date/Time Prepared: 2/28/2014 1:51 pm
			Rural Health Clinic (RHC) I	Cost

				1.00		
1.00	Clinic Address and Identification			321 WEST WASHINGTON		1.00
			City	State	Zip Code	
			1.00	2.00	3.00	
2.00	City, State, Zip Code, County			IL 62363		2.00
				1.00		
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban			Grant Award	Date	3.00
				1.00	2.00	
Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N		0 10.00
			Sunday	Monday	Tuesday	
			from to	from to	from	
			1.00 2.00	3.00 4.00	5.00	
11.00	Facility hours of operations (1)			07:00	17:30	07:00
				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		0 12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			N		0 13.00
			Provider name	CCN number		
			1.00	2.00		
14.00	Provider name, CCN number					14.00
			Y/N	V	XVIII	XIX
			1.00	2.00	3.00	4.00
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)			0	0	0
			Total Visits			5.00
				County		
				4.00		
2.00	City, State, Zip Code, County			PIKE		2.00
			Tuesday	wednesday	Thursday	
			to	from to	from to	
			6.00	7.00 8.00	9.00 10.00	
11.00	Facility hours of operations (1)			17:30	07:00	17:30
				17:00	17:30	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141315 Component CCN: 143482	Period: From 10/01/2012 To 09/30/2013	Worksheet S-8 Date/Time Prepared: 2/28/2014 1:51 pm		
			Rural Health Clinic (RHC) I	Cost		
		Friday		Saturday		
		from	to	from	to	
		11.00	12.00	13.00	14.00	
11.00	Facility hours of operations (1) Clinic	07:00	17:30	07:00	12:00	11.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
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)			0.413374	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			1,152,172	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			351,562	5.00
6.00	Medicaid charges			7,414,440	6.00
7.00	Medicaid cost (line 1 times line 6)			3,064,937	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)			1,561,203	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)			1,561,203	19.00
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,170,835	765,033	1,935,868	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	483,993	316,245	800,238	21.00
22.00	Partial payment by patients approved for charity care	259	433	692	22.00
23.00	Cost of charity care (line 21 minus line 22)	483,734	315,812	799,546	23.00
				1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			2,142,528	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			517,885	27.00
28.00	Non-Medicare and Non-Reimbursable Medicare bad debt expense (line 26 minus line 27)			1,624,643	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			671,585	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			1,471,131	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			3,032,334	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet A

Date/Time Prepared:
2/28/2014 1:51 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		396,651	396,651	53,389	450,040	1.00
2.00	00200		607,023	607,023	4,912	611,935	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400		2,467,160	2,467,160	0	2,467,160	4.00
5.00	00500	1,201,687	1,643,278	2,844,965	20,231	2,865,196	5.00
6.00	00600	309,930	251,313	561,243	0	561,243	6.00
7.00	00700	0	315,521	315,521	88,752	404,273	7.00
8.00	00800	0	91,441	91,441	0	91,441	8.00
9.00	00900	247,520	45,009	292,529	0	292,529	9.00
10.00	01000	187,731	97,850	285,581	0	285,581	10.00
11.00	01100	0	0	0	0	0	11.00
13.00	01300	224,038	45,003	269,041	-118,983	150,058	13.00
16.00	01600	28,014	210,800	238,814	0	238,814	16.00
17.00	01700	0	0	0	32,769	32,769	17.00
19.00	01900	0	0	0	272,166	272,166	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,016,105	38,409	1,054,514	-33,618	1,020,896	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	391,097	144,465	535,562	-1,510	534,052	50.00
53.00	05300	272,166	3,217	275,383	-275,383	0	53.00
54.00	05400	671,181	533,664	1,204,845	0	1,204,845	54.00
54.01	03451	66,837	71,921	138,758	-20,349	118,409	54.01
60.00	06000	478,163	637,987	1,116,150	-83,362	1,032,788	60.00
65.00	06500	122,777	53,898	176,675	-20,061	156,614	65.00
65.01	06501	37,700	10,328	48,028	0	48,028	65.01
66.00	06600	148,352	69,947	218,299	-214	218,085	66.00
71.00	07100	44,688	122,783	167,471	131,956	299,427	71.00
73.00	07300	315,579	1,734,689	2,050,268	-737	2,049,531	73.00
73.01	07301	132,117	311,339	443,456	-647	442,809	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	429,973	764,373	1,194,346	0	1,194,346	88.00
91.00	09100	711,560	1,896,212	2,607,772	-722	2,607,050	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		95,362	95,362	0	95,362	113.00
118.00		7,037,215	12,659,643	19,696,858	48,589	19,745,447	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	123,403	5,171	128,574	-288	128,286	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	0	0	0	0	0	193.04
193.05	19305	106,303	54,518	160,821	-48,301	112,520	193.05
200.00		7,266,921	12,719,332	19,986,253	0	19,986,253	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet A

Date/Time Prepared:
2/28/2014 1:51 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	450,040	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-218,807	393,128	2.00
3.00	00300 OTHER CAP REL COSTS	0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-504,463	1,962,697	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	818,748	3,683,944	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	561,243	6.00
7.00	00700 OPERATION OF PLANT	-2,883	401,390	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	-5,718	85,723	8.00
9.00	00900 HOUSEKEEPING	0	292,529	9.00
10.00	01000 DIETARY	-49,259	236,322	10.00
11.00	01100 CAFETERIA	0	0	11.00
13.00	01300 NURSING ADMINISTRATION	0	150,058	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	12,912	251,726	16.00
17.00	01700 SOCIAL SERVICE	0	32,769	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	272,166	19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	0	1,020,896	30.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0	534,052	50.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	-17,649	1,187,196	54.00
54.01	03451 NUCLEAR MEDICINE - DIAGNOSTIC	0	118,409	54.01
60.00	06000 LABORATORY	-5,856	1,026,932	60.00
65.00	06500 RESPIRATORY THERAPY	0	156,614	65.00
65.01	06501 SLEEP STUDIES	0	48,028	65.01
66.00	06600 PHYSICAL THERAPY	0	218,085	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-3,705	295,722	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	39,652	2,089,183	73.00
73.01	07301 ONCOLOGY	-300,000	142,809	73.01
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	-8,233	1,186,113	88.00
91.00	09100 EMERGENCY	-1,351,588	1,255,462	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE	-95,362	0	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,692,211	18,053,236	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	128,286	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	112,520	193.05
200.00	TOTAL (SUM OF LINES 118-199)	-1,692,211	18,294,042	200.00

Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
6.00	MAINTENANCE & REPAIRS	00600		6.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
19.00	NONPHYSICIAN ANESTHETISTS	01900		19.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01	NUCLEAR MEDICINE - DIAGNOSTIC	03451		54.01
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
65.01	SLEEP STUDIES	06501		65.01
66.00	PHYSICAL THERAPY	06600		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
73.01	ONCOLOGY	07301		73.01
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)	09200		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	INTEREST EXPENSE	11300		113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
193.00	NONPAID WORKERS	19300		193.00
193.01	AUTOMATED HEALTH SERVICES	19301		193.01
193.02	RENAL	19302		193.02
193.03	LEASED SPACE	19303		193.03
193.04	UNUSED SPACE	19304		193.04
193.05	WELLNESS	19305		193.05
200.00	TOTAL (SUM OF LINES 118-199)			200.00

	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	88,752	1.00
	TOTALS		0	88,752	
C - RECLASS MEDICAL SUPPLIES EXPENSE					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	131,956	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
	TOTALS		0	131,956	
E - RECLASS SOCIAL SERVICE SALARY					
1.00	SOCIAL SERVICE	17.00	32,769	0	1.00
	TOTALS		32,769	0	
F - RECLASS MISC ANESTHESIA EXPENSE					
1.00	OPERATING ROOM	50.00	0	2,940	1.00
	TOTALS		0	2,940	
H - RECLASS CRNA COSTS					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	272,166	0	1.00
	TOTALS		272,166	0	
I - RECLASS UR COORDINATOR SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	32,588	0	1.00
	TOTALS		32,588	0	
J - RECLASS NURSING MANAGER SALARY					
1.00	ADMINISTRATIVE & GENERAL	5.00	86,395	0	1.00
	TOTALS		86,395	0	
K - RECLASS BUILDING RENT					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	48,301	1.00
	TOTALS		0	48,301	
500.00	Grand Total: Increases		423,918	281,949	500.00

		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	88,752	0	1.00
	TOTALS		0	88,752		
C - RECLASS MEDICAL SUPPLIES EXPENSE						
1.00	ADULTS & PEDIATRICS	30.00	0	849	0	1.00
2.00	OPERATING ROOM	50.00	0	4,450	0	2.00
3.00	ANESTHESIOLOGY	53.00	0	277	0	3.00
4.00	NUCLEAR MEDICINE - DIAGNOSTIC	54.01	0	20,349	0	4.00
5.00	LABORATORY	60.00	0	83,362	0	5.00
6.00	RESPIRATORY THERAPY	65.00	0	20,061	0	6.00
7.00	PHYSICAL THERAPY	66.00	0	214	0	7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	737	0	8.00
9.00	ONCOLOGY	73.01	0	647	0	9.00
10.00	EMERGENCY	91.00	0	722	0	10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	288	0	11.00
	TOTALS		0	131,956		
E - RECLASS SOCIAL SERVICE SALARY						
1.00	ADULTS & PEDIATRICS	30.00	32,769	0	0	1.00
	TOTALS		32,769	0		
F - RECLASS MISC ANESTHESIA EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	2,940	0	1.00
	TOTALS		0	2,940		
H - RECLASS CRNA COSTS						
1.00	ANESTHESIOLOGY	53.00	272,166	0	0	1.00
	TOTALS		272,166	0		
I - RECLASS UR COORDINATOR SALARY						
1.00	NURSING ADMINISTRATION	13.00	32,588	0	0	1.00
	TOTALS		32,588	0		
J - RECLASS NURSING MANAGER SALARY						
1.00	NURSING ADMINISTRATION	13.00	86,395	0	0	1.00
	TOTALS		86,395	0		
K - RECLASS BUILDING RENT						
1.00	WELLNESS	193.05	0	48,301	10	1.00
	TOTALS		0	48,301		
500.00	Grand Total: Decreases		423,918	281,949		500.00

	Increases			Decreases			
	Cost Center	Line #	Salary	Cost Center	Line #	Salary	
	2.00	3.00	4.00	6.00	7.00	8.00	
	A - RECLASS PROPERTY INSURANCE						
1.00	OTHER CAP REL COSTS	3.00		ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS			TOTALS		0	
	B - RECLASS UTILITIES						
1.00	OPERATION OF PLANT	7.00		ADMINISTRATIVE & GENERAL	5.00	0	1.00
	TOTALS			TOTALS		0	
	C - RECLASS MEDICAL SUPPLIES EXPENSE						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		ADULTS & PEDIATRICS	30.00	0	1.00
2.00		0.00		OPERATING ROOM	50.00	0	2.00
3.00		0.00		ANESTHESIOLOGY	53.00	0	3.00
4.00		0.00		NUCLEAR MEDICINE - DIAGNOSTIC	54.01	0	4.00
5.00		0.00		LABORATORY	60.00	0	5.00
6.00		0.00		RESPIRATORY THERAPY	65.00	0	6.00
7.00		0.00		PHYSICAL THERAPY	66.00	0	7.00
8.00		0.00		DRUGS CHARGED TO PATIENTS	73.00	0	8.00
9.00		0.00		ONCOLOGY	73.01	0	9.00
10.00		0.00		EMERGENCY	91.00	0	10.00
11.00		0.00		PHYSICIANS' PRIVATE OFFICES	192.00	0	11.00
	TOTALS			TOTALS		0	
	E - RECLASS SOCIAL SERVICE SALARY						
1.00	SOCIAL SERVICE	17.00	32,769	ADULTS & PEDIATRICS	30.00	32,769	1.00
	TOTALS		32,769	TOTALS		32,769	
	F - RECLASS MISC ANESTHESIA EXPENSE						
1.00	OPERATING ROOM	50.00		ANESTHESIOLOGY	53.00	0	1.00
	TOTALS			TOTALS		0	
	H - RECLASS CRNA COSTS						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	272,166	ANESTHESIOLOGY	53.00	272,166	1.00
	TOTALS		272,166	TOTALS		272,166	
	I - RECLASS UR COORDINATOR SALARY						
1.00	ADMINISTRATIVE & GENERAL	5.00	32,588	NURSING ADMINISTRATION	13.00	32,588	1.00
	TOTALS		32,588	TOTALS		32,588	
	J - RECLASS NURSING MANAGER SALARY						
1.00	ADMINISTRATIVE & GENERAL	5.00	86,395	NURSING ADMINISTRATION	13.00	86,395	1.00
	TOTALS		86,395	TOTALS		86,395	
	K - RECLASS BUILDING RENT						
1.00	CAP REL COSTS-BLDG & FIXT	1.00		WELLNESS	193.05	0	1.00
	TOTALS			TOTALS		0	
500.00	Grand Total: Increases		423,918	Grand Total: Decreases		423,918	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-7
Part I
Date/Time Prepared:
2/28/2014 1:51 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	138,751	0	0	0	1.00
2.00	Land Improvements	289,167	14,500	0	14,500	2.00
3.00	Buildings and Fixtures	6,493,876	0	0	0	3.00
4.00	Building Improvements	896,708	45,987	0	45,987	4.00
5.00	Fixed Equipment	0	0	0	0	5.00
6.00	Movable Equipment	6,769,618	579,379	0	579,379	168,865
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,588,120	639,866	0	639,866	168,865
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	14,588,120	639,866	0	639,866	168,865
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	138,751	0			1.00
2.00	Land Improvements	303,667	0			2.00
3.00	Buildings and Fixtures	6,493,876	0			3.00
4.00	Building Improvements	942,695	0			4.00
5.00	Fixed Equipment	0	0			5.00
6.00	Movable Equipment	7,180,132	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	15,059,121	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	15,059,121	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-7
Part II
Date/Time Prepared:
2/28/2014 1:51 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	396,651	0	0	0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	607,023	0	0	0	0	2.00	
3.00	Total (sum of lines 1-2)	1,003,674	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	396,651					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	607,023					2.00
3.00	Total (sum of lines 1-2)	0	1,003,674					3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-7
Part III
Date/Time Prepared:
2/28/2014 1:51 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL	
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance
		1.00	2.00	3.00	4.00	5.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	7,436,571	0	7,436,571	0.508772	5,088
2.00	CAP REL COSTS-MVBLE EQUIP	7,180,133	0	7,180,133	0.491228	4,912
3.00	Total (sum of lines 1-2)	14,616,704	0	14,616,704	1.000000	10,000
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL	
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	5,088	396,651	48,301
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	4,912	388,216	0
3.00	Total (sum of lines 1-2)	0	0	10,000	784,867	48,301
Cost Center Description		SUMMARY OF CAPITAL				
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related costs (see instructions)	Total (2) (sum of cols. 9 through 14)
		11.00	12.00	13.00	14.00	15.00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	5,088	0	0	450,040
2.00	CAP REL COSTS-MVBLE EQUIP	0	4,912	0	0	393,128
3.00	Total (sum of lines 1-2)	0	10,000	0	0	843,168

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
	1.00	2.00	3.00	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	-95,362		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	-1,657,444				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	511,490				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 employees and others		0			0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00	0 16.00
17.00 Sale of drugs to other than patients		0			0.00	0 17.00
18.00 Sale of medical records and abstracts	B	-476		MEDICAL RECORDS & LIBRARY	16.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0 19.00
20.00 Vending machines		0			0.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0		RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0		PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0		*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0		CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
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		0			0.00	0 32.00
33.00 MISCELLANEOUS INCOME	B	-7,008		ADMINISTRATIVE & GENERAL	5.00	0 33.00
33.01 MISCELLANEOUS RADIOLOGY INCOME	B	-935		RADIOLOGY-DIAGNOSTIC	54.00	0 33.01

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

worksheet A-8

Date/Time Prepared:
2/28/2014 1:51 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on worksheet A To/From which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
	1.00	2.00	3.00	4.00	5.00	
33.02 MISCELLANEOUS SUPPLIES REVENUE	B	-3,705	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		0 33.02
33.03 CABLE TELEVISION	A	-2,883	OPERATION OF PLANT	7.00		0 33.03
33.04 MISCELLANEOUS EXPENSE	A	-24,324	ADMINISTRATIVE & GENERAL	5.00		0 33.04
33.05 PUBLIC RELATIONS SALARIES	A	-25,755	ADMINISTRATIVE & GENERAL	5.00		0 33.05
33.06 PUBLIC RELATIONS EMPLOYEE BENEFITS	A	-8,744	EMPLOYEE BENEFITS DEPARTMENT	4.00		0 33.06
33.07 PUBLIC RELATIONS EXPENSES	A	-74,234	ADMINISTRATIVE & GENERAL	5.00		0 33.07
33.08 COFFEE SHOP RECEIPTS	B	-46,730	DIETARY	10.00		0 33.08
33.09 MEALS ON WHEELS	B	-2,630	DIETARY	10.00		0 33.09
33.10 LOBBYING EXPENSE	A	-10,820	ADMINISTRATIVE & GENERAL	5.00		0 33.10
33.11 NON-RHC PHYSICIAN COST	A	-23,844	RURAL HEALTH CLINIC	88.00		0 33.11
33.12 CAH HIT ADJUSTMENT FOR DEPRECIATION	A	0		0.00		0 33.12
33.13	A	-218,807	CAP REL COSTS-MVBLE EQUIP	2.00		9 33.13
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200.)		-1,692,211				50.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet A-8-1

Date/Time Prepared:
2/28/2014 1:51 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	1,116,341	499,454 1.00
2.00	10.00	DIETARY	DIETICIAN	5,586	5,485 2.00
3.00	8.00	LAUNDRY & LINEN SERVICE	LAUNDRY SERVICES	52,625	58,343 3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HEALTH INSURANCE	0	495,719 4.00
4.01	88.00	RURAL HEALTH CLINIC	RHC PHYSICIAN	494,626	467,139 4.01
4.02	5.00	ADMINISTRATIVE & GENERAL	ACCOUNTS PAYABLE COSTS	5,002	6,696 4.02
4.03	88.00	RURAL HEALTH CLINIC	RHC CLINIC BUILDING	8,073	19,949 4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	PFS AND PATIENT ACCESS	446,949	101,253 4.04
4.05	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	170,949	157,561 4.05
4.06	54.00	RADIOLOGY-DIAGNOSTIC	ECHO SERVICES	7,630	24,344 4.06
4.07	73.00	DRUGS CHARGED TO PATIENTS	PHARMACY SERVICES	75,652	36,000 4.07
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to worksheet A-8, column 2, line 12.			2,383,433	1,871,943 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.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			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 10/01/2012
To 09/30/2013

Worksheet A-8-1
Date/Time Prepared:
2/28/2014 1:51 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	616,887	0	1.00
2.00	101	0	2.00
3.00	-5,718	0	3.00
4.00	-495,719	0	4.00
4.01	27,487	0	4.01
4.02	-1,694	5	4.02
4.03	-11,876	0	4.03
4.04	345,696	0	4.04
4.05	13,388	0	4.05
4.06	-16,714	0	4.06
4.07	39,652	0	4.07
5.00	511,490		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	HOME OFFICE	6.00
7.00	HOSPITAL	7.00
8.00	LAUNDRY	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 10/01/2012
To 09/30/2013

Worksheet A-8-2

Date/Time Prepared:
2/28/2014 1:51 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	60.00	LABORATORY	5,856	5,856	0	0	0
2.00	73.01	ONCOLOGY	300,000	300,000	0	0	0
3.00	91.00	EMERGENCY	1,832,804	1,351,588	481,216	0	0
4.00	13.00	NURSING ADMINISTRATION	2,150	0	2,150	0	0
5.00	0.00		0	0	0	0	0
6.00	0.00		0	0	0	0	0
7.00	0.00		0	0	0	0	0
8.00	0.00		0	0	0	0	0
9.00	0.00		0	0	0	0	0
10.00	0.00		0	0	0	0	0
200.00			2,140,810	1,657,444	483,366	0	0

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance
	1.00	2.00	8.00	9.00	12.00	13.00	14.00
1.00	60.00	LABORATORY	0	0	0	0	0
2.00	73.01	ONCOLOGY	0	0	0	0	0
3.00	91.00	EMERGENCY	0	0	0	0	0
4.00	13.00	NURSING ADMINISTRATION	0	0	0	0	0
5.00	0.00		0	0	0	0	0
6.00	0.00		0	0	0	0	0
7.00	0.00		0	0	0	0	0
8.00	0.00		0	0	0	0	0
9.00	0.00		0	0	0	0	0
10.00	0.00		0	0	0	0	0
200.00			0	0	0	0	0

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment
	1.00	2.00	15.00	16.00	17.00	18.00
1.00	60.00	LABORATORY	0	0	0	5,856
2.00	73.01	ONCOLOGY	0	0	0	300,000
3.00	91.00	EMERGENCY	0	0	0	1,351,588
4.00	13.00	NURSING ADMINISTRATION	0	0	0	0
5.00	0.00		0	0	0	0
6.00	0.00		0	0	0	0
7.00	0.00		0	0	0	0
8.00	0.00		0	0	0	0
9.00	0.00		0	0	0	0
10.00	0.00		0	0	0	0
200.00			0	0	0	1,657,444

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141315	Period: From 10/01/2012 To 09/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/28/2014 1:51 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)			80	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)			70	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	154.79	155.07	0.00	0.00
10.00	AHSEA (see instructions)	107.41	79.21	59.41	0.00	0.00
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)	39.61	39.61	29.71		
12.00	Number of travel hours (provider site)	0	0	0		
12.01	Number of travel hours (offsite)	0	0	0		
13.00	Number of miles driven (provider site)	0	0	0		
13.01	Number of miles driven (offsite)	0	0	0		
			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)			12,261	15.00	
16.00	Assistants (column 3, line 9 times column 3, line 10)			9,213	16.00	
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)			21,474	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)			21,474	20.00	
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)			69.30	21.00	
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)			54,054	22.00	
23.00	Total salary equivalency (see instructions)			54,054	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)			3,169	24.00	
25.00	Assistants (line 4 times column 3, line 11)			2,080	25.00	
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)			5,249	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)			518	27.00	
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)			5,767	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)			5,767	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 10/01/2012 To 09/30/2013	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/28/2014 1:51 pm
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	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
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	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)	79.21	59.41	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)		54,054	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		5,767	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)		59,821	63.00
64.00	Total cost of outside supplier services (from your records)		22,088	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		5,249	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		518	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		5,767	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		518	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		518	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 10/01/2012
To 09/30/2013

Worksheet B
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Cost Center Description	Net Expenses for Cost Allocation (from wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	450,040	450,040			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	393,128		393,128		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,962,697	0	0	1,962,697	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	3,683,944	80,446	78,983	350,982	5.00
6.00 00600	MAINTENANCE & REPAIRS	561,243	84,434	82,902	84,006	6.00
7.00 00700	OPERATION OF PLANT	401,390	0	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	85,723	0	0	0	8.00
9.00 00900	HOUSEKEEPING	292,529	6,552	6,433	67,090	9.00
10.00 01000	DIETARY	236,322	7,995	7,849	50,884	10.00
11.00 01100	CAFETERIA	0	2,890	2,837	0	11.00
13.00 01300	NURSING ADMINISTRATION	150,058	541	531	28,475	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	251,726	9,929	9,748	7,593	16.00
17.00 01700	SOCIAL SERVICE	32,769	516	507	8,882	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	272,166	0	0	73,770	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,020,896	32,841	32,244	266,530	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	534,052	24,544	24,097	106,006	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,187,196	16,293	15,996	181,922	54.00
54.01 03451	NUCLEAR MEDICINE - DIAGNOSTIC	118,409	1,865	1,831	18,116	54.01
60.00 06000	LABORATORY	1,026,932	8,900	8,739	129,605	60.00
65.00 06500	RESPIRATORY THERAPY	156,614	2,327	2,285	33,278	65.00
65.01 06501	SLEEP STUDIES	48,028	952	935	10,218	65.01
66.00 06600	PHYSICAL THERAPY	218,085	12,220	11,997	40,210	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	295,722	6,646	6,525	12,113	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,089,183	5,953	5,845	85,537	73.00
73.01 07301	ONCOLOGY	142,809	5,202	5,108	35,810	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	1,186,113	0	12,316	116,543	88.00
91.00 09100	EMERGENCY	1,255,462	22,058	21,657	192,866	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)	18,053,236	333,104	339,365	1,900,436	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,378	2,334	0	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	128,286	23,793	23,361	33,448	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	8,309	0	0	193.02
193.03 19303	LEASED SPACE	0	21,452	0	0	193.03
193.04 19304	UNUSED SPACE	0	32,416	0	0	193.04
193.05 19305	WELLNESS	112,520	28,588	28,068	28,813	193.05
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	18,294,042	450,040	393,128	1,962,697	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

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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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	4,194,355					5.00
6.00	00600	241,727	1,054,312				6.00
7.00	00700	119,405	0	520,795			7.00
8.00	00800	25,501	0	0	111,224		8.00
9.00	00900	110,842	26,038	12,312	0	521,796	9.00
10.00	01000	90,151	31,773	15,024	0	17,516	10.00
11.00	01100	1,704	11,485	5,431	0	6,331	11.00
13.00	01300	53,429	2,151	1,017	0	1,186	13.00
16.00	01600	82,995	39,459	18,658	0	21,753	16.00
17.00	01700	12,695	2,050	970	0	1,130	17.00
19.00	01900	102,909	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	402,344	130,520	61,718	111,224	71,955	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	204,873	97,542	46,124	0	53,774	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	416,889	64,751	30,618	0	35,696	54.00
54.01	03451	41,713	7,413	3,505	0	4,087	54.01
60.00	06000	349,293	35,372	16,726	0	19,500	60.00
65.00	06500	57,861	9,248	4,373	0	5,098	65.00
65.01	06501	17,888	3,785	1,790	0	2,087	65.01
66.00	06600	84,041	48,563	22,964	0	26,772	66.00
71.00	07100	95,493	26,411	12,489	0	14,560	71.00
73.00	07300	650,435	23,658	11,187	0	13,042	73.00
73.01	07301	56,202	20,676	9,777	0	11,398	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	391,177	49,854	0	0	0	88.00
91.00	09100	443,851	87,663	41,453	0	48,328	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		4,053,418	718,412	316,136	111,224	354,213	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,402	9,449	4,468	0	5,209	190.00
192.00	19200	62,140	94,560	44,714	0	52,130	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	2,472	33,021	15,614	0	18,204	193.02
193.03	19303	6,382	85,255	25,221	0	29,405	193.03
193.04	19304	9,643	0	60,918	0	0	193.04
193.05	19305	58,898	113,615	53,724	0	62,635	193.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		4,194,355	1,054,312	520,795	111,224	521,796	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141315

Period:
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To 09/30/2013

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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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	457,514					10.00
11.00	01100	0	30,678				11.00
13.00	01300	0	620	238,008			13.00
16.00	01600	0	165	0	442,026		16.00
17.00	01700	0	193	0	0	59,712	17.00
19.00	01900	0	1,605	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	457,514	5,802	83,695	19,809	59,712	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	2,307	33,600	24,726	0	50.00
53.00	05300	0	0	0	1,192	0	53.00
54.00	05400	0	3,959	184	135,797	0	54.00
54.01	03451	0	394	3,514	9,953	0	54.01
60.00	06000	0	2,820	3	82,914	0	60.00
65.00	06500	0	724	6,980	18,496	0	65.00
65.01	06501	0	222	0	4,447	0	65.01
66.00	06600	0	875	0	9,576	0	66.00
71.00	07100	0	264	0	11,585	0	71.00
73.00	07300	0	1,861	0	58,514	0	73.00
73.01	07301	0	779	14,853	4,142	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	2,536	17,881	0	0	88.00
91.00	09100	0	4,197	68,204	60,875	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		457,514	29,323	228,914	442,026	59,712	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	728	9,094	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	0	0	0	0	0	193.04
193.05	19305	0	627	0	0	0	193.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		457,514	30,678	238,008	442,026	59,712	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part I
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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					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
16.00	01600					16.00
17.00	01700					17.00
19.00	01900	450,450				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	0	2,756,804	0	2,756,804	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	0	1,151,645	0	1,151,645	50.00
53.00	05300	450,450	451,642	0	451,642	53.00
54.00	05400	0	2,089,301	0	2,089,301	54.00
54.01	03451	0	210,800	0	210,800	54.01
60.00	06000	0	1,680,804	0	1,680,804	60.00
65.00	06500	0	297,284	0	297,284	65.00
65.01	06501	0	90,352	0	90,352	65.01
66.00	06600	0	475,303	0	475,303	66.00
71.00	07100	0	481,808	0	481,808	71.00
73.00	07300	0	2,945,215	0	2,945,215	73.00
73.01	07301	0	306,756	0	306,756	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	0	1,776,420	0	1,776,420	88.00
91.00	09100	0	2,246,614	0	2,246,614	91.00
92.00	09200	0		0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		450,450	16,960,748	0	16,960,748	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	0	25,240	0	25,240	190.00
192.00	19200	0	472,254	0	472,254	192.00
193.00	19300	0	0	0	0	193.00
193.01	19301	0	0	0	0	193.01
193.02	19302	0	77,620	0	77,620	193.02
193.03	19303	0	167,715	0	167,715	193.03
193.04	19304	0	102,977	0	102,977	193.04
193.05	19305	0	487,488	0	487,488	193.05
200.00		0	0	0	0	200.00
201.00		0	0	0	0	201.00
202.00		450,450	18,294,042	0	18,294,042	202.00

Provider CCN: 141315

Period:
 From 10/01/2012
 To 09/30/2013

Worksheet Non-CMS W

Date/Time Prepared:
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Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-5	ACCUM. COST	5.00
6.00	MAINTENANCE & REPAIRS	6	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	7	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	8	PATIENT DAYS	8.00
9.00	HOUSEKEEPING	9	SQUARE FEET	9.00
10.00	DIETARY	8	PATIENT DAYS	10.00
11.00	CAFETERIA	4	GROSS SALARIES	11.00
13.00	NURSING ADMINISTRATION	13	NURSING SALARIES	13.00
16.00	MEDICAL RECORDS & LIBRARY	16	TOTAL CHARGES	16.00
17.00	SOCIAL SERVICE	8	PATIENT DAYS	17.00
19.00	NONPHYSICIAN ANESTHETISTS	19	ASSIGNED TIME	19.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT
		BLDG & FIXT	MVBLE EQUIP		
	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	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	80,446	159,429	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	84,434	167,336	6.00
7.00 00700	OPERATION OF PLANT	0	0	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	6,552	12,985	9.00
10.00 01000	DIETARY	0	7,995	15,844	10.00
11.00 01100	CAFETERIA	0	2,890	5,727	11.00
13.00 01300	NURSING ADMINISTRATION	0	541	1,072	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	9,929	19,677	16.00
17.00 01700	SOCIAL SERVICE	0	516	1,023	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	0	32,841	65,085	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	24,544	48,641	50.00
53.00 05300	ANESTHESIOLOGY	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	16,293	32,289	54.00
54.01 03451	NUCLEAR MEDICINE - DIAGNOSTIC	0	1,865	3,696	54.01
60.00 06000	LABORATORY	0	8,900	17,639	60.00
65.00 06500	RESPIRATORY THERAPY	0	2,327	4,612	65.00
65.01 06501	SLEEP STUDIES	0	952	1,887	65.01
66.00 06600	PHYSICAL THERAPY	0	12,220	24,217	66.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,646	13,171	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	5,953	11,798	73.00
73.01 07301	ONCOLOGY	0	5,202	10,310	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800	RURAL HEALTH CLINIC	0	0	12,316	88.00
91.00 09100	EMERGENCY	0	22,058	43,715	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	333,104	672,469	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,378	4,712	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	23,793	47,154	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	0	8,309	8,309	193.02
193.03 19303	LEASED SPACE	0	21,452	21,452	193.03
193.04 19304	UNUSED SPACE	0	32,416	32,416	193.04
193.05 19305	WELLNESS	0	28,588	56,656	193.05
200.00	Cross Foot Adjustments			0	200.00
201.00	Negative Cost Centers			0	201.00
202.00	TOTAL (sum lines 118-201)	0	450,040	843,168	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141315

Period:
From 10/01/2012
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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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	159,429					5.00
6.00	00600	9,188	176,524				6.00
7.00	00700	4,539	0	4,539			7.00
8.00	00800	969	0	0	969		8.00
9.00	00900	4,213	4,360	107	0	21,665	9.00
10.00	01000	3,427	5,320	131	0	727	10.00
11.00	01100	65	1,923	47	0	263	11.00
13.00	01300	2,031	360	9	0	49	13.00
16.00	01600	3,155	6,607	163	0	903	16.00
17.00	01700	483	343	8	0	47	17.00
19.00	01900	3,911	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	15,293	21,852	537	969	2,985	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	7,787	16,332	402	0	2,233	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	15,846	10,841	267	0	1,482	54.00
54.01	03451	1,585	1,241	31	0	170	54.01
60.00	06000	13,276	5,922	146	0	810	60.00
65.00	06500	2,199	1,548	38	0	212	65.00
65.01	06501	680	634	16	0	87	65.01
66.00	06600	3,194	8,131	200	0	1,112	66.00
71.00	07100	3,630	4,422	109	0	605	71.00
73.00	07300	24,725	3,961	98	0	542	73.00
73.01	07301	2,136	3,462	85	0	473	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	14,868	8,347	0	0	0	88.00
91.00	09100	16,871	14,678	361	0	2,007	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		154,071	120,284	2,755	969	14,707	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	53	1,582	39	0	216	190.00
192.00	19200	2,362	15,832	390	0	2,164	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	94	5,529	136	0	756	193.02
193.03	19303	243	14,274	220	0	1,221	193.03
193.04	19304	367	0	531	0	0	193.04
193.05	19305	2,239	19,023	468	0	2,601	193.05
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		159,429	176,524	4,539	969	21,665	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part II
Date/Time Prepared:
2/28/2014 1:51 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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	25,449					10.00
11.00	01100	0	8,025				11.00
13.00	01300	0	162	3,683			13.00
16.00	01600	0	43	0	30,548		16.00
17.00	01700	0	51	0	0	1,955	17.00
19.00	01900	0	420	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	25,449	1,518	1,295	1,370	1,955	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	603	520	1,710	0	50.00
53.00	05300	0	0	0	82	0	53.00
54.00	05400	0	1,036	3	9,371	0	54.00
54.01	03451	0	103	54	688	0	54.01
60.00	06000	0	738	0	5,734	0	60.00
65.00	06500	0	189	108	1,279	0	65.00
65.01	06501	0	58	0	308	0	65.01
66.00	06600	0	229	0	662	0	66.00
71.00	07100	0	69	0	801	0	71.00
73.00	07300	0	487	0	4,047	0	73.00
73.01	07301	0	204	230	286	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	663	277	0	0	88.00
91.00	09100	0	1,098	1,055	4,210	0	91.00
92.00	09200	0	0	0	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		25,449	7,671	3,542	30,548	1,955	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	190	141	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	0	0	0	0	0	193.04
193.05	19305	0	164	0	0	0	193.05
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		25,449	8,025	3,683	30,548	1,955	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet B
Part II
Date/Time Prepared:
2/28/2014 1:51 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					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100					11.00
13.00	01300					13.00
16.00	01600					16.00
17.00	01700					17.00
19.00	01900	4,331				19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000		138,308	0	138,308	30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000		78,228	0	78,228	50.00
53.00	05300		82	0	82	53.00
54.00	05400		71,135	0	71,135	54.00
54.01	03451		7,568	0	7,568	54.01
60.00	06000		44,265	0	44,265	60.00
65.00	06500		10,185	0	10,185	65.00
65.01	06501		3,670	0	3,670	65.01
66.00	06600		37,745	0	37,745	66.00
71.00	07100		22,807	0	22,807	71.00
73.00	07300		45,658	0	45,658	73.00
73.01	07301		17,186	0	17,186	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00	08800		36,471	0	36,471	88.00
91.00	09100		83,995	0	83,995	91.00
92.00	09200			0		92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		0	597,303	0	597,303	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000		6,602	0	6,602	190.00
192.00	19200		68,233	0	68,233	192.00
193.00	19300		0	0	0	193.00
193.01	19301		0	0	0	193.01
193.02	19302		14,824	0	14,824	193.02
193.03	19303		37,410	0	37,410	193.03
193.04	19304		33,314	0	33,314	193.04
193.05	19305		81,151	0	81,151	193.05
200.00		4,331	4,331	0	4,331	200.00
201.00		0	0	0	0	201.00
202.00		4,331	843,168	0	843,168	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1

Date/Time Prepared:
2/28/2014 1:51 pm

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
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	7,241,166		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,298	22,298	1,294,915	-4,194,355	5.00
6.00	00600	MAINTENANCE & REPAIRS	23,404	23,404	309,930	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	1,816	1,816	247,520	0	9.00
10.00	01000	DIETARY	2,216	2,216	187,731	0	10.00
11.00	01100	CAFETERIA	801	801	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	150	150	105,055	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,752	2,752	28,014	0	16.00
17.00	01700	SOCIAL SERVICE	143	143	32,769	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	272,166	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,103	9,103	983,336	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,803	6,803	391,097	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,516	4,516	671,181	0	54.00
54.01	03451	NUCLEAR MEDICINE - DIAGNOSTIC	517	517	66,837	0	54.01
60.00	06000	LABORATORY	2,467	2,467	478,163	0	60.00
65.00	06500	RESPIRATORY THERAPY	645	645	122,777	0	65.00
65.01	06501	SLEEP STUDIES	264	264	37,700	0	65.01
66.00	06600	PHYSICAL THERAPY	3,387	3,387	148,352	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,842	1,842	44,688	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,650	1,650	315,580	0	73.00
73.01	07301	ONCOLOGY	1,442	1,442	132,116	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,477	429,973	0	88.00
91.00	09100	EMERGENCY	6,114	6,114	711,560	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)	92,330	95,807	7,011,460	-4,194,355	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	659	659	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,595	6,595	123,403	0	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	2,303	0	0	0	193.02
193.03	19303	LEASED SPACE	5,946	0	0	0	193.03
193.04	19304	UNUSED SPACE	8,985	0	0	0	193.04
193.05	19305	WELLNESS	7,924	7,924	106,303	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)	450,040	393,128	1,962,697		202.00
203.00		Unit cost multiplier (wkst. B, Part I)	3.607766	3.542172	0.271047		203.00
204.00		Cost to be allocated (per wkst. B, Part II)			0		204.00
205.00		Unit cost multiplier (wkst. B, Part II)			0.000000		205.00

Cost 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	73,532				6.00
7.00	00700	OPERATION OF PLANT	0	76,814			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1,264		8.00
9.00	00900	HOUSEKEEPING	1,816	1,816	0	66,013	9.00
10.00	01000	DIETARY	2,216	2,216	0	2,216	10.00
11.00	01100	CAFETERIA	801	801	0	801	11.00
13.00	01300	NURSING ADMINISTRATION	150	150	0	150	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,752	2,752	0	2,752	16.00
17.00	01700	SOCIAL SERVICE	143	143	0	143	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	9,103	9,103	1,264	9,103	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,803	6,803	0	6,803	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,516	4,516	0	4,516	54.00
54.01	03451	NUCLEAR MEDICINE - DIAGNOSTIC	517	517	0	517	54.01
60.00	06000	LABORATORY	2,467	2,467	0	2,467	60.00
65.00	06500	RESPIRATORY THERAPY	645	645	0	645	65.00
65.01	06501	SLEEP STUDIES	264	264	0	264	65.01
66.00	06600	PHYSICAL THERAPY	3,387	3,387	0	3,387	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,842	1,842	0	1,842	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,650	1,650	0	1,650	73.00
73.01	07301	ONCOLOGY	1,442	1,442	0	1,442	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,477	0	0	0	88.00
91.00	09100	EMERGENCY	6,114	6,114	0	6,114	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)	50,105	46,628	1,264	44,812	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	659	659	0	659	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,595	6,595	0	6,595	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	2,303	2,303	0	2,303	193.02
193.03	19303	LEASED SPACE	5,946	3,720	0	3,720	193.03
193.04	19304	UNUSED SPACE	0	8,985	0	0	193.04
193.05	19305	WELLNESS	7,924	7,924	0	7,924	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)	1,054,312	520,795	111,224	521,796	457,514
203.00		Unit cost multiplier (wkst. B, Part I)	14.338138	6.779949	87.993671	7.904443	361.957278
204.00		Cost to be allocated (per wkst. B, Part II)	176,524	4,539	969	21,665	25,449
205.00		Unit cost multiplier (wkst. B, Part II)	2.400642	0.059091	0.766614	0.328193	20.133703

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet B-1

Date/Time Prepared:
2/28/2014 1:51 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						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	5,201,070					11.00
13.00	01300	105,055	1,979,720				13.00
16.00	01600	28,014	0	39,749,058			16.00
17.00	01700	32,769	0	0	1,264		17.00
19.00	01900	272,166	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	983,336	696,166	1,781,345	1,264		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	391,097	279,478	2,223,554	0	0	50.00
53.00	05300	0	0	107,183	0	100	53.00
54.00	05400	671,181	1,528	12,210,674	0	0	54.00
54.01	03451	66,837	29,225	895,015	0	0	54.01
60.00	06000	478,163	22	7,456,306	0	0	60.00
65.00	06500	122,777	58,062	1,663,283	0	0	65.00
65.01	06501	37,700	0	399,898	0	0	65.01
66.00	06600	148,352	0	861,116	0	0	66.00
71.00	07100	44,688	0	1,041,794	0	0	71.00
73.00	07300	315,580	0	5,262,046	0	0	73.00
73.01	07301	132,116	123,549	372,482	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	429,973	148,732	0	0	0	88.00
91.00	09100	711,560	567,316	5,474,362	0	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		4,971,364	1,904,078	39,749,058	1,264	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	123,403	75,642	0	0	0	192.00
193.00	19300	0	0	0	0	0	193.00
193.01	19301	0	0	0	0	0	193.01
193.02	19302	0	0	0	0	0	193.02
193.03	19303	0	0	0	0	0	193.03
193.04	19304	0	0	0	0	0	193.04
193.05	19305	106,303	0	0	0	0	193.05
200.00							200.00
201.00							201.00
202.00		30,678	238,008	442,026	59,712	450,450	202.00
203.00		0.005898	0.120223	0.011120	47.240506	4,504.500000	203.00
204.00		8,025	3,683	30,548	1,955	4,331	204.00
205.00		0.001543	0.001860	0.000769	1.546677	43.310000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/28/2014 1:51 pm

Cost Center Description	Total Cost (From Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Title XVIII		Hospital		
			Total Costs	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		2,756,804		0	2,756,804	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM		1,151,645		0	1,151,645	50.00
53.00	05300 ANESTHESIOLOGY		451,642		0	451,642	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		2,089,301		0	2,089,301	54.00
54.01	03451 NUCLEAR MEDICINE - DIAGNOSTIC		210,800		0	210,800	54.01
60.00	06000 LABORATORY		1,680,804		0	1,680,804	60.00
65.00	06500 RESPIRATORY THERAPY	0	297,284		0	297,284	65.00
65.01	06501 SLEEP STUDIES	0	90,352		0	90,352	65.01
66.00	06600 PHYSICAL THERAPY	0	475,303		0	475,303	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		481,808		0	481,808	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,945,215		0	2,945,215	73.00
73.01	07301 ONCOLOGY		306,756		0	306,756	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC		1,776,420		0	1,776,420	88.00
91.00	09100 EMERGENCY		2,246,614		0	2,246,614	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		208,328			208,328	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)		17,169,076	0		17,169,076	200.00
201.00	Less observation Beds		208,328			208,328	201.00
202.00	Total (see instructions)		16,960,748	0		16,960,748	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/28/2014 1:51 pm

Cost Center Description		Title XVIII			Hospital	Cost		
		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,566,211		1,566,211			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,022	2,210,532	2,223,554	0.517930	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,911	105,272	107,183	4.213747	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	441,753	11,768,921	12,210,674	0.171104	0.000000	54.00
54.01	03451	NUCLEAR MEDICINE - DIAGNOSTIC	3,614	891,401	895,015	0.235527	0.000000	54.01
60.00	06000	LABORATORY	594,413	6,861,893	7,456,306	0.225420	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	589,818	1,073,465	1,663,283	0.178733	0.000000	65.00
65.01	06501	SLEEP STUDIES	0	399,898	399,898	0.225938	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	151,714	709,402	861,116	0.551962	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	359,780	682,014	1,041,794	0.462479	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	619,271	4,642,775	5,262,046	0.559709	0.000000	73.00
73.01	07301	ONCOLOGY	0	372,482	372,482	0.823546	0.000000	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,280,930	1,280,930			88.00
91.00	09100	EMERGENCY	43,223	5,431,139	5,474,362	0.410388	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	215,134	215,134	0.968364	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	4,384,730	36,645,258	41,029,988			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,384,730	36,645,258	41,029,988			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet C
Part I
Date/Time Prepared:
2/28/2014 1:51 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
INPATIENT ROUTINE SERVICE COST CENTERS		11.00			
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	03451 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	07301 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 10/01/2012 To 09/30/2013		Worksheet D Part II Date/Time Prepared: 2/28/2014 1:51 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	78,228	2,223,554	0.035182	9,503	334	50.00
53.00	05300	ANESTHESIOLOGY	82	107,183	0.000765	1,911	1	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	71,135	12,210,674	0.005826	337,325	1,965	54.00
54.01	03451	NUCLEAR MEDICINE - DIAGNOSTIC	7,568	895,015	0.008456	2,255	19	54.01
60.00	06000	LABORATORY	44,265	7,456,306	0.005937	454,892	2,701	60.00
65.00	06500	RESPIRATORY THERAPY	10,185	1,663,283	0.006123	444,229	2,720	65.00
65.01	06501	SLEEP STUDIES	3,670	399,898	0.009177	0	0	65.01
66.00	06600	PHYSICAL THERAPY	37,745	861,116	0.043833	53,291	2,336	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	22,807	1,041,794	0.021892	273,181	5,980	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	45,658	5,262,046	0.008677	462,314	4,011	73.00
73.01	07301	ONCOLOGY	17,186	372,482	0.046139	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	36,471	1,280,930	0.028472	0	0	88.00
91.00	09100	EMERGENCY	83,995	5,474,362	0.015343	9,159	141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	215,134	0.000000	0	0	92.00
200.00		Total (lines 50-199)	458,995	39,463,777		2,048,060	20,208	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/28/2014 1:51 pm

Cost Center Description		Title XVIII			Hospital	Cost		
		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	450,450	0	0	0	450,450	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03451	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	07301	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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)	450,450	0	0	0	450,450	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
2/28/2014 1:51 pm

Cost Center Description		Title XVIII			Hospital			
		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	2,223,554	0.000000	0.000000	9,503	50.00
53.00	05300	ANESTHESIOLOGY	0	107,183	4.202625	0.000000	1,911	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,210,674	0.000000	0.000000	337,325	54.00
54.01	03451	NUCLEAR MEDICINE - DIAGNOSTIC	0	895,015	0.000000	0.000000	2,255	54.01
60.00	06000	LABORATORY	0	7,456,306	0.000000	0.000000	454,892	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,663,283	0.000000	0.000000	444,229	65.00
65.01	06501	SLEEP STUDIES	0	399,898	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	861,116	0.000000	0.000000	53,291	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,041,794	0.000000	0.000000	273,181	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,262,046	0.000000	0.000000	462,314	73.00
73.01	07301	ONCOLOGY	0	372,482	0.000000	0.000000	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,280,930	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	5,474,362	0.000000	0.000000	9,159	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	215,134	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	39,463,777			2,048,060	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

worksheet D
Part IV
Date/Time Prepared:
2/28/2014 1:51 pm

Cost-Center Description		Title XVIII					Hospital	Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before 1/1	Outpatient Program Charges on/after 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before 1/1	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after 1/1		
		11.00	12.00	12.01	13.00	13.01		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	8,031	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03451	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	07301	ONCOLOGY	0	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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)	8,031	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description	Title XVIII				Hospital Other Medical Education Cost	Cost	
	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PSA Adj. Allied Health	PSA Adj. All			
	21.00	22.00	23.00	24.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03451	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141315	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/28/2014 1:51 pm
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Cost Center Description		Cost to Charge Ratio From Worksheet G, Part I, col. 9	Charges	Hospital		Cost
			PPS Reimbursed Services (see Inst.) before 1/1	PPS Reimbursed Services (see Inst.) on/after 1/1	Cost Reimbursed Services Subject to Ded. & Coins. (see Inst.)	Cost Reimbursed Services Not Subject to Ded. & Coins. (see Inst.)
		1.00	2.00	2.01	3.00	4.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.517930	0	0	1,268,251	0
53.00	05300 ANESTHESIOLOGY	4.213747	0	0	43,386	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.171104	0	0	4,865,009	0
54.01	03451 NUCLEAR MEDICINE - DIAGNOSTIC	0.235527	0	0	569,368	0
60.00	06000 LABORATORY	0.225420	0	0	3,391,738	0
65.00	06500 RESPIRATORY THERAPY	0.178733	0	0	630,817	0
65.01	06501 SLEEP STUDIES	0.225938	0	0	134,634	0
66.00	06600 PHYSICAL THERAPY	0.551962	0	0	280,220	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.462479	0	0	352,465	0
73.00	07300 DRUGS CHARGED TO PATIENTS	0.559709	0	0	2,946,715	0
73.01	07301 ONCOLOGY	0.823546	0	0	200,430	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
91.00	09100 EMERGENCY	0.410388	0	0	1,953,676	0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.968364	0	0	141,665	0
200.00	Subtotal (see instructions)		0	0	16,778,374	0
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0	0
202.00	Net Charges (Line 200 +/- Line 201)		0	0	16,778,374	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet D
Part V
Date/Time Prepared:
2/28/2014 1:51 pm

Cost Center Description	Title XVIII				Hospital	Cost	
	Costs		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1					
	5.00	5.01	6.00	7.00			
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	656,865	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	182,818	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	832,422	0	54.00
54.01	03451	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	134,102	0	54.01
60.00	06000	LABORATORY	0	0	764,566	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	112,748	0	65.00
65.01	06501	SLEEP STUDIES	0	0	30,419	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	154,671	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	163,008	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,649,303	0	73.00
73.01	07301	ONCOLOGY	0	0	165,063	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	801,765	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	137,183	0	92.00
200.00		Subtotal (see instructions)	0	0	5,784,933	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	5,784,933	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141315	Period: From 10/01/2012 To 09/30/2013	Worksheet D Part V Date/Time Prepared: 2/28/2014 1:51 pm
	Component CCN: 142315		

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.) before 1/1	PPS Reimbursed Services (see inst.) on/after 1/1	Charges		Cost
		1.00	2.00	2.01	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	3.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)
						4.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.517930	0	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	4.213747	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.171104	0	0	0	0	54.00
54.01	03451 NUCLEAR MEDICINE - DIAGNOSTIC	0.235527	0	0	0	0	54.01
60.00	06000 LABORATORY	0.225420	0	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.178733	0	0	0	0	65.00
65.01	06501 SLEEP STUDIES	0.225938	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.551962	0	0	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.462479	0	0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.559709	0	0	0	0	73.00
73.01	07301 ONCOLOGY	0.823546	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000					88.00
91.00	09100 EMERGENCY	0.410388	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.968364	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

Period: From 10/01/2012

Worksheet D

Component CCN: 142315

To 09/30/2013

Part V

Date/Time Prepared: 2/28/2014 1:51 pm

Cost Center Description		Title XVIII				Swing Beds - SNF	Cost
		Costs					
		PPS Services (see inst.) before 1/1	PPS Services (see inst.) on/after 1/1	Cost Reimbursed Services subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not subject To Ded. & Coins. (see inst.)		
		5.00	5.01	6.00	7.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	03451	NUCLEAR MEDICINE - DIAGNOSTIC	0	0	0	0	54.01
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP STUDIES	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	ONCOLOGY	0	0	0	0	73.01
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	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		201.00
202.00		Net charges (line 200 +/- line 201)	0	0	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141315	Period: From 10/01/2012 To 09/30/2013	Worksheet D-1 Date/Time Prepared: 2/28/2014 1:51 pm
Cost Center Description		Title XVIII	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,367	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,173	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		1,070	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		48	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)		142	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)		3	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		879	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)		48	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)		142	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		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,756,804	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		384,294	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,372,510	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)		2,372,510	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)		2,022.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,777,865	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)		1,777,865	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-1

Date/Time Prepared:
2/28/2014 1:51 pm

Cost Center Description	Title XVIII			Hospital Program Days	Cost Program Cost (col. 3 x col. 4)
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)		
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00
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)					671,438
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,449,303
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
51.00 Pass through costs applicable to Program inpatient ancillary services (from wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					0
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
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
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
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
62.00 Relief payment (see instructions)					0
63.00 Allowable inpatient cost plus incentive payment (see instructions)					0
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)					97,085
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					287,209
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					384,294
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
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
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
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)					103
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					2,022.60
89.00 Observation bed cost (line 87 x line 88) (see instructions)					208,328

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-1

Date/Time Prepared:
2/28/2014 1:51 pm

Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Hospital Total Observation Bed Cost (from line 89)	Cost	
					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	0	0	0.000000	0	0	90.00
91.00 Nursing School cost	0	0	0.000000	0	0	91.00
92.00 Allied health cost	0	0	0.000000	0	0	92.00
93.00 All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet D-3

Date/Time Prepared:
2/28/2014 1:51 pm

Cost Center Description		Ratio of Cost To Charges	Hospital Inpatient Program Charges	Cost Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		1,162,351		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.517930	9,503	4,922	50.00
53.00	05300 ANESTHESIOLOGY	4.213747	1,911	8,052	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.171104	337,325	57,718	54.00
54.01	03451 NUCLEAR MEDICINE - DIAGNOSTIC	0.235527	2,255	531	54.01
60.00	06000 LABORATORY	0.225420	454,892	102,542	60.00
65.00	06500 RESPIRATORY THERAPY	0.178733	444,229	79,398	65.00
65.01	06501 SLEEP STUDIES	0.225938	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.551962	53,291	29,415	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.462479	273,181	126,340	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.559709	462,314	258,761	73.00
73.01	07301 ONCOLOGY	0.823546	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.410388	9,159	3,759	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.968364	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,048,060	671,438	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		2,048,060		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141315

Period:

Worksheet D-3

Component CCN: 142315

From 10/01/2012

To 09/30/2013

Date/Time Prepared:
2/28/2014 1:51 pm

Cost Center Description		Title XVIII		Cost	
		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	0.517930	0	0	50.00
53.00	05300 ANESTHESIOLOGY	4.213747	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.171104	12,772	2,185	54.00
54.01	03451 NUCLEAR MEDICINE - DIAGNOSTIC	0.235527	0	0	54.01
60.00	06000 LABORATORY	0.225420	18,038	4,066	60.00
65.00	06500 RESPIRATORY THERAPY	0.178733	44,418	7,939	65.00
65.01	06501 SLEEP STUDIES	0.225938	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.551962	83,135	45,887	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.462479	22,230	10,281	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.559709	34,747	19,448	73.00
73.01	07301 ONCOLOGY	0.823546	0	0	73.01
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100 EMERGENCY	0.410388	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.968364	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		215,340	89,806	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		215,340		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141315	Period: From 10/01/2012 To 09/30/2013	Worksheet E Part B Date/Time Prepared: 2/28/2014 1:51 pm
		Title XVIII	Hospital	Cost
			before 1/1	on/after 1/1
			1.00	1.01
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,784,933	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)		5,784,933	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)		5,842,782	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		37,034	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		2,677,407	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)		3,128,341	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)		3,128,341	30.00
31.00	Primary payer payments		318	31.00
32.00	Subtotal (line 30 minus line 31)		3,128,023	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)		543,326	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		478,127	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		543,326	36.00
37.00	Subtotal (see instructions)		3,606,150	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		3,606,150	40.00
40.01	Sequestration adjustment (see instructions)		36,062	40.01
41.00	Interim payments		3,812,461	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-242,373	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00
				Overrides
				1.00
WORKSHEET OVERRIDE VALUES				
112.00	override of Ancillary service charges (line 12)		0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
2/28/2014 1:51 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		1,641,437		3,625,454	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	03/27/2013	120,530	03/27/2013	100,792	3.01	
3.02		09/17/2013	30,223	09/17/2013	86,215	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)		150,753		187,007	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)		1,792,190		3,812,461	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		518,871		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		242,373	6.02	
7.00	Total Medicare program liability (see instructions)		2,311,061		3,570,088	7.00	
			0	Contractor Number	NPR Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141315
Component CCN: 14Z315

Period:
From 10/01/2012
To 09/30/2013

worksheet E-1
Part I
Date/Time Prepared:
2/28/2014 1:51 pm

		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		313,830		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	03/27/2013	29,885		0		3.01
3.02		09/17/2013	6,920		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)		36,805		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)		350,635		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		118,794		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		469,429		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

Period:

worksheet E-2

Component CCN: 142315

From 10/01/2012

Date/Time Prepared:

To 09/30/2013

2/28/2014 1:51 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)	388,137	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 5 and 7, line 202 for Part B) (For CAH, see instructions)	90,704	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	190	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)	478,841	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	478,841	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)	478,841	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,670	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)	474,171	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
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)	474,171	0	19.00
19.01	Sequestration adjustment (see instructions)	4,742	0	19.01
20.00	Interim payments	350,635	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	118,794	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 10/01/2012 To 09/30/2013	Worksheet E-3 Part V Date/Time Prepared: 2/28/2014 1:51 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT (CAHS)				
1.00	Inpatient services		2,449,303	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)		2,449,303	4.00
5.00	Primary payer payments		1,441	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)		2,472,355	6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges		0	7.00
8.00	Ancillary service charges		0	8.00
9.00	Organ acquisition charges, net of revenue		0	9.00
10.00	Total reasonable charges		0	10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)		0.000000	13.00
14.00	Total customary charges (see instructions)		0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		0	16.00
17.00	Cost of teaching physicians (from worksheet D-5, Part II, column 3, line 20) (see instructions)		0	17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from worksheet E-4, line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)		2,472,355	19.00
20.00	Deductibles (exclude professional component)		176,228	20.00
21.00	Excess reasonable cost (from line 16)		0	21.00
22.00	Subtotal (line 19 minus line 20)		2,296,127	22.00
23.00	Coinsurance		1,480	23.00
24.00	Subtotal (line 22 minus line 23)		2,294,647	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		45,179	25.00
26.00	Adjusted reimbursable bad debts (see instructions)		39,758	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		45,179	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)		2,334,405	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)		2,334,405	30.00
30.01	Sequestration adjustment (see instructions)		23,344	30.01
31.00	Interim payments		1,792,190	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		518,871	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	34.00

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

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet G

Date/Time Prepared:
2/28/2014 1:51 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	4,396,896	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	12,926,780	0	0	0	4.00
5.00	Other receivable	249,857	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,425,609	0	0	0	6.00
7.00	Inventory	471,094	0	0	0	7.00
8.00	Prepaid expenses	130,174	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)	10,749,192	0	0	0	11.00
FIXED ASSETS						
12.00	Land	138,751	0	0	0	12.00
13.00	Land improvements	303,667	0	0	0	13.00
14.00	Accumulated depreciation	-247,443	0	0	0	14.00
15.00	Buildings	7,581,539	0	0	0	15.00
16.00	Accumulated depreciation	-3,858,485	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	7,180,134	0	0	0	23.00
24.00	Accumulated depreciation	-5,421,368	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	5,676,795	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	3,461	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	88,023	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	91,484	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	16,517,471	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	468,523	0	0	0	37.00
38.00	Salaries, wages, and fees payable	778,810	0	0	0	38.00
39.00	Payroll taxes payable	28,741	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	0	0	0	42.00
43.00	Due to other funds	220,179	0	0	0	43.00
44.00	Other current liabilities	1,930,385	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,426,638	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	3,900,459	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	93,431	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,993,890	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	7,420,528	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	9,096,943	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	9,096,943	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	16,517,471	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet G-1

Date/Time Prepared:
2/28/2014 1:51 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		7,163,079		0	1.00
2.00	Net income (loss) (from wkst. G-3, line 29)		1,691,953			2.00
3.00	Total (sum of line 1 and line 2)		8,855,032		0	3.00
4.00	CAPITAL CONTRIBUTION	5,169		0		4.00
5.00	RELEASED FROM RESTRICTIONS	88,866		0		5.00
6.00	CONTRIBUTIONS	317,543		0		6.00
7.00	OTHER	4,133		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		415,711		0	10.00
11.00	Subtotal (line 3 plus line 10)		9,270,743		0	11.00
12.00	RELEASED FROM RESTRICTIONS	164,498		0		12.00
13.00	WCIT	9,302		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		173,800		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		9,096,943		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	CAPITAL CONTRIBUTION		0			4.00
5.00	RELEASED FROM RESTRICTIONS		0			5.00
6.00	CONTRIBUTIONS		0			6.00
7.00	OTHER		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	WCIT		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 10/01/2012
To 09/30/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/28/2014 1:51 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,450,313		1,450,313	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	114,574		114,574	5.00
6.00	Swing bed - NF	2,412		2,412	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)	1,567,299		1,567,299	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)	1,567,299		1,567,299	17.00
18.00	Ancillary services	2,985,537	39,439,284	42,424,821	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	1,280,930	1,280,930	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)	4,552,836	40,720,214	45,273,050	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per wkst. A, column 3, line 200)		19,986,253		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)		19,986,253		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141315

Period:
From 10/01/2012
To 09/30/2013

Worksheet G-3

Date/Time Prepared:
2/28/2014 1:51 pm

		1,00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	45,273,050	1.00
2.00	Less contractual allowances and discounts on patients' accounts	24,228,205	2.00
3.00	Net patient revenues (line 1 minus line 2)	21,044,845	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	19,986,253	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,058,592	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	8,886	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS INCOME	624,475	24.00
25.00	Total other income (sum of lines 6-24)	633,361	25.00
26.00	Total (line 5 plus line 25)	1,691,953	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)	1,691,953	29.00

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

Provider CCN: 141315
Component CCN: 143482

Period:
From 10/01/2012
To 09/30/2013

Worksheet M-1
Date/Time Prepared:
2/28/2014 1:51 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
2.00	Physician Assistant	0	0	0	0	0
3.00	Nurse Practitioner	89,737	0	89,737	0	89,737
4.00	Visiting Nurse	0	0	0	0	0
5.00	Other Nurse	0	0	0	0	0
6.00	Clinical Psychologist	0	0	0	0	0
7.00	Clinical Social Worker	8,795	0	8,795	0	8,795
8.00	Laboratory Technician	4,493	0	4,493	0	4,493
9.00	Other Facility Health Care Staff Costs	179,246	0	179,246	0	179,246
10.00	Subtotal (sum of lines 1-9)	282,271	0	282,271	0	282,271
11.00	Physician Services Under Agreement	0	467,139	467,139	0	467,139
12.00	Physician Supervision Under Agreement	0	0	0	0	0
13.00	Other Costs Under Agreement	0	187,765	187,765	0	187,765
14.00	Subtotal (sum of lines 11-13)	0	654,904	654,904	0	654,904
15.00	Medical supplies	0	0	0	0	0
16.00	Transportation (Health Care Staff)	0	0	0	0	0
17.00	Depreciation-Medical Equipment	0	0	0	0	0
18.00	Professional Liability Insurance	0	0	0	0	0
19.00	Other Health Care Costs	0	28,514	28,514	0	28,514
20.00	Allowable GME Costs	0	0	0	0	0
21.00	Subtotal (sum of lines 15-20)	0	28,514	28,514	0	28,514
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	282,271	683,418	965,689	0	965,689
COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0
24.00	Dental	0	0	0	0	0
25.00	Optometry	0	0	0	0	0
26.00	All other nonreimbursable costs	0	0	0	0	0
27.00	Nonallowable GME costs	0	0	0	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23-27)	0	0	0	0	0
FACILITY OVERHEAD						
29.00	Facility Costs	0	38,223	38,223	0	38,223
30.00	Administrative Costs	147,702	42,732	190,434	0	190,434
31.00	Total Facility Overhead (sum of lines 29 and 30)	147,702	80,955	228,657	0	228,657
32.00	Total facility costs (sum of lines 22, 28 and 31)	429,973	764,373	1,194,346	0	1,194,346

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141315 Component CCN: 143482	Period: From 10/01/2012 To 09/30/2013	Worksheet M-1 Date/Time Prepared: 2/28/2014 1:51 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	89,737	3.00
4.00 Visiting Nurse	0	0	4.00
5.00 Other Nurse	0	0	5.00
6.00 Clinical Psychologist	0	0	6.00
7.00 Clinical Social Worker	0	8,795	7.00
8.00 Laboratory Technician	0	4,493	8.00
9.00 Other Facility Health Care Staff Costs	0	179,246	9.00
10.00 Subtotal (sum of lines 1-9)	0	282,271	10.00
11.00 Physician Services Under Agreement	3,643	470,782	11.00
12.00 Physician Supervision Under Agreement	0	0	12.00
13.00 Other Costs Under Agreement	0	187,765	13.00
14.00 Subtotal (sum of lines 11-13)	3,643	658,547	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	28,514	19.00
20.00 Allowable GME Costs	0	0	20.00
21.00 Subtotal (sum of lines 15-20)	0	28,514	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,643	969,332	22.00
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00 Pharmacy	0	0	23.00
24.00 Dental	0	0	24.00
25.00 Optometry	0	0	25.00
26.00 All other nonreimbursable costs	0	0	26.00
27.00 Nonallowable GME costs	0	0	27.00
28.00 Total Nonreimbursable Costs (sum of lines 23-27)	0	0	28.00
FACILITY OVERHEAD			
29.00 Facility Costs	-11,876	26,347	29.00
30.00 Administrative Costs	0	190,434	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	-11,876	216,781	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	-8,233	1,186,113	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141315

Period: From 10/01/2012

Worksheet M-2

Component CCN: 143482

To 09/30/2013

Date/Time Prepared: 2/28/2014 1:51 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	5,285	4,200	7,224		1.00
2.00 Physician Assistant	0.00	0	2,100	0		2.00
3.00 Nurse Practitioner	0.89	2,116	2,100	1,869		3.00
4.00 Subtotal (sum of lines 1-3)	2.61	7,401		9,093	9,093	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	4			4	7.00
7.01 Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02 Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00 Total FTEs and visits (sum of lines 4-7)	2.61	7,405			9,097	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)	969,332	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)	969,332	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)	216,781	14.00
15.00 Parent provider overhead allocated to facility (see instructions)	590,307	15.00
16.00 Total overhead (sum of lines 14 and 15)	807,088	16.00
17.00 Allowable GME overhead (see instructions)	0	17.00
18.00 Subtract line 17 from line 16	807,088	18.00
19.00 Overhead applicable to RHC/FQHC services (line 13 x line 18)	807,088	19.00
20.00 Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	1,776,420	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN:141315
Component CCN:143482

Period:
From 10/01/2012
To 09/30/2013

Worksheet M-3
Date/Time Prepared:
2/28/2014 1:51 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)				1,776,420 1.00
2.00	Cost of vaccines and their administration (from worksheet M-4, line 15)				9,213 2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)				1,767,207 3.00
4.00	Total visits (from worksheet M-2, column 5, line 8)				9,097 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)				9,097 6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)				194.26 7.00
		Calculation of Limit (1)			
		Prior to January 1	On or After January 1		
		1.00	2.00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	78.54	79.17		8.00
9.00	Rate for Program covered visits (see instructions)	194.26	194.26		9.00
CALCULATION OF SETTLEMENT					
10.00	Program covered visits excluding mental health services (from contractor records)	584	1,203		10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	113,448	233,695		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) *		347,143		16.00
16.01	Total program charges (see instructions)(from contractor's records)		276,316		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0		16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0		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.)		266,233		16.04
16.05	Total program cost (see instructions)		266,233		16.05
17.00	Primary payer amounts		0		17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		14,352		18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		52,393		19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		266,233		20.00
21.00	Program cost of vaccines and their administration (from wkst. M-4, line 16)		4,471		21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		270,704		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)		270,704		26.00
26.01	Sequestration adjustment (see instructions)		2,707		26.01
27.00	Interim payments		246,213		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		21,784		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	Period: From 10/01/2012 To 09/30/2013	Worksheet M-4
		Component CCN: 143482		Date/Time Prepared: 2/28/2014 1:51 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)	282,271	282,271	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000136	0.002321	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	38	655	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,516	2,818	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,554	3,473	5.00
6.00	Total direct cost of the facility (from worksheet M-1, column 7, line 22)	969,332	969,332	6.00
7.00	Total overhead (from worksheet M-2, line 16)	807,088	807,088	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001603	0.003583	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,294	2,892	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,848	6,365	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	17	289	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	167.53	22.02	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	5	165	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	838	3,633	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)		9,213	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)		4,471	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 10/01/2012 To 09/30/2013	Worksheet M-5 Date/Time Prepared: 2/28/2014 1:51 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			224,577 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		03/27/2013	21,636	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		21,636	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		246,213	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		21,784	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		267,997	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00 2.00
8.00	Name of Contractor			8.00