

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: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet S Parts I-III Date/Time Prepared: 5/18/2015 9:34 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 5/18/2015 Time: 9:34 am	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PARIS COMMUNITY HOSPITAL (141320) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-211,468	-748,549	1	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	-145,746	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		109,314		0	10.00
10.01 RURAL HEALTH CLINIC II	0		17,333		0	10.01
10.02 RURAL HEALTH CLINIC III	0		2,404		0	10.02
200.00 Total	0	-357,214	-619,498	1	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part I Date/Time Prepared: 5/18/2015 9:22 am
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1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 61944-		4.00 County: EDGAR		1.00
1.00	Street: 721 EAST COURT STREET	State: IL		Zip Code: 61944-		County: EDGAR		2.00
2.00	City: PARIS							

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	PARIS COMMUNITY HOSPITAL	141320	14999	1	06/30/2002	N	0	0	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	PARIS COMMUNITY HOSPITAL	14Z320	14999		06/30/2002	N	0	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FMC	143987	14999		09/24/1994	N	0	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	HATCH	143989	14999		01/01/1995	N	0	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	FMC	143431	14999		02/16/1997	N	0	N	15.02
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

						From:	To:		
						1.00	2.00		

20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2014	12/31/2014	20.00
21.00	Type of Control (see instructions)	2		21.00

Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					N	N			22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N			22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2	N			23.00

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days			
							1.00	2.00	3.00
24.00	0	0	0	0	0	0	0	0	24.00

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	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
	1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25.00
					Urban/Rural	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.				1		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.				1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.				0		35.00	
					Beginning:	Ending:		
					1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.						36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.				0		37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.						38.00	
					Y/N	Y/N		
					1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)				N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)				N	N	40.00	
					V	XVIII	XIX	
					1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)				N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.				N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.				N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.				N	N	N	48.00
Teaching Hospitals								
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.				N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.							58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.				N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)				N			60.00
		Y/N	IME	Direct GME	IME	Direct GME		
		1.00	2.00	3.00	4.00	5.00		
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)			0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)			0.00	0.00			61.02

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)	0.00	0.00				61.03
61.04	Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).	0.00	0.00				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)	0.00	0.00				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.00	0.00				61.06
	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count			
	1.00	2.00	3.00	4.00			
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00			61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.		0.00	0.00			61.20
					1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)					N	63.00
	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))				
	1.00	2.00	3.00				
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00		0.000000	64.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		

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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		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N			75.00

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		1.00	2.00	3.00			
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			0	76.00		
		1.00					
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00		
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00		
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00		
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00		
		V		XIX			
		1.00		2.00			
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00			0.00	97.00	
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			Y	105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N	106.00		
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)			N	107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N	108.00		
		Physical	Occupational	Speech	Respiratory		
		1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00	
					1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N		110.00	
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, §2208.1.			N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N	116.00		
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			N	117.00		
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			0	118.00		

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	
		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	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y	121.00	
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N	125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00	
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		N	140.00	
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:	Contractor's Number:		
142.00	Street:	PO Box:			
143.00	City:	State:	Zip Code:		
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00	
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the 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, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N	146.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N	149.00	
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141320		Period: From 01/01/2014 To 12/31/2014		Worksheet S-2 Part I Date/Time Prepared: 5/18/2015 9:22 am		
							1.00	
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							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)				01/01/2014	12/31/2014		170.00
							1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)						N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/18/2015 9:22 am	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	12/31/2014	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	Type	Date	
		1.00	2.00	3.00	
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		Legal Oper.	
		1.00		2.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	04/13/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Prepared: 5/18/2015 9:22 am	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
		1.00	2.00	3.00	
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JAKE	CARNAZZO		41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923476	JCARNAZZO@ALLIANTMANAGEMENT.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)	04/13/2015		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00
			3.00	
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141320

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

Worksheet S-3
Part I
Date/Time Prepared:
5/18/2015 9:22 am

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	34,320.00	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	34,320.00	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	34,320.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.01 RURAL HEALTH CLINIC II	88.01				0	26.01
26.02 RURAL HEALTH CLINIC III	88.02				0	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		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: 141320

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

Worksheet S-3
Part I
Date/Time Prepared:
5/18/2015 9:22 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	911	135	1,430			1.00
2.00 HMO and other (see instructions)	57	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	808	0	808			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	2,627			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,719	135	4,865			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)	1,719	135	4,865	0.00	171.38	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	7,572	0	33,839	0.00	49.59	26.00
26.01 RURAL HEALTH CLINIC II	329	0	1,710	0.00	2.87	26.01
26.02 RURAL HEALTH CLINIC III	86	0	531	0.00	0.97	26.02
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	224.81	27.00
28.00 Observation Bed Days		0	161			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 141320

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

Worksheet S-3
Part I
Date/Time Prepared:
5/18/2015 9:22 am

Component	Full Time Equivalents	Discharges			Total All Patients		
		Nonpaid Workers	Title V	Title XVIII			Title XIX
		11.00	12.00	13.00			14.00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	290	62	480	1.00
2.00	HMO and other (see instructions)			18	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	290	62	480	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part IV Date/Time Prepared: 5/18/2015 9:22 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		363,257	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		3,347,360	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		77,522	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		47,017	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		118,293	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		942,383	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		19,665	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		2,900	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		4,918,397	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141320 Component CCN: 143987		Period: From 01/01/2014 To 12/31/2014		Worksheet S-8 Date/Time Prepared: 5/18/2015 9:22 am	
				Rural Health Clinic (RHC) I		Cost	
1.00							
Clinic Address and Identification							
1.00 Street		727 EAST COURT STREET				1.00	
		City		State		Zip Code	
2.00 City, State, Zip Code, County		PARIS		IL		61944	
1.00							
3.00 FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban							
0							
3.00							
Grant Award							
Date							
1.00							
2.00							
Source of Federal Funds							
4.00 Community Health Center (Section 330(d), PHS Act)				0		4.00	
5.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
6.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
7.00 Appalachian Regional Commission				0		7.00	
8.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
9.01				0		9.01	
9.02				0		9.02	
9.03				0		9.03	
9.04				0		9.04	
9.05				0		9.05	
9.06				0		9.06	
9.07				0		9.07	
9.08				0		9.08	
9.09				0		9.09	
9.10				0		9.10	
1.00							
2.00							
10.00 Does this facility operate as other than an RHC or FOHC? 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	
		Sunday		Monday		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)							
11.00 Clinic		08:00		17:00		08:00	
1.00							
2.00							
12.00 Have you received an approval for an exception to the productivity standard?		N				12.00	
13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N				0	
		1.00		2.00		3.00	
		4.00		5.00		6.00	
Provider name							
CCN number							
14.00 Provider name, CCN number							
		Y/N		V		Total Visits	
		1.00		2.00		3.00	
		4.00		5.00		6.00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		N		0		0	
		1.00		2.00		3.00	
		4.00		5.00		6.00	
		7.00		8.00		9.00	
		10.00		11.00		12.00	
		13.00		14.00		15.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141320 Component CCN: 143987		Period: From 01/01/2014 To 12/31/2014		Worksheet S-8 Date/Time Prepared: 5/18/2015 9:22 am	
				Rural Health Clinic (RHC) I		Cost	
		County 4.00					
2.00	City, State, Zip Code, County	EDGAR				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)							
11.00	Clinic	17:00	08:00	19:00	08:00	19:00	11.00
		Friday		Saturday			
		from to		from to			
		11.00 12.00		13.00 14.00			
Facility hours of operations (1)							
11.00	Clinic	08:00	19:00	08:00	11:30		11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141320 Component CCN: 143989		Period: From 01/01/2014 To 12/31/2014		Worksheet S-8 Date/Time Prepared: 5/18/2015 9:22 am	
				Rural Health Clinic (RHC) II		Cost	
1.00							
Clinic Address and Identification							
1.00 Street		City		State		Zip Code	
		1.00		2.00		3.00	
2.00 City, State, Zip Code, County		CHRI SMAN		IL		61924	
1.00							
3.00 FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban							
0							
Grant Award							
Date							
1.00							
2.00							
Source of Federal Funds							
4.00 Community Health Center (Section 330(d), PHS Act)				0		4.00	
5.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
6.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
7.00 Appalachian Regional Commission				0		7.00	
8.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
9.01				0		9.01	
9.02				0		9.02	
9.03				0		9.03	
9.04				0		9.04	
9.05				0		9.05	
9.06				0		9.06	
9.07				0		9.07	
9.08				0		9.08	
9.09				0		9.09	
9.10				0		9.10	
1.00							
2.00							
10.00 Does this facility operate as other than an RHC or FOHC? 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	
		Sunday		Monday		Tuesday	
		from to		from to		from	
		1.00 2.00		3.00 4.00		5.00	
Facility hours of operations (1)							
11.00 Clinic		08:00		12:00		13:30	
1.00							
2.00							
12.00 Have you received an approval for an exception to the productivity standard?		N				12.00	
13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N				0	
Provider name							
CCN number							
1.00							
2.00							
14.00 Provider name, CCN number		Y/N		V		Total Visits	
		1.00		2.00		3.00 4.00 5.00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		N		0		0	
				0		0	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141320 Component CCN: 143989		Period: From 01/01/2014 To 12/31/2014		Worksheet S-8 Date/Time Prepared: 5/18/2015 9:22 am	
				Rural Health Clinic (RHC) II		Cost	
		County 4.00					
2.00	City, State, Zip Code, County	EDGAR				2.00	
		Tuesday		Wednesday		Thursday	
		to		from to		from to	
		6.00		7.00 8.00		9.00 10.00	
Facility hours of operations (1)							
11.00	Clinic	19:30		08:00		12:00	
		Friday		Saturday			
		from to		from to			
		11.00 12.00		13.00 14.00			
Facility hours of operations (1)							
11.00	Clinic	08:00		12:00			

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141320 Component CCN: 143431		Period: From 01/01/2014 To 12/31/2014		Worksheet S-8 Date/Time Prepared: 5/18/2015 9:22 am	
				Rural Health Clinic (RHC) III		Cost	
1.00							
Clinic Address and Identification							
1.00 Street		104 BUENA VISTA				1.00	
		City		State		Zip Code	
		1.00		2.00		3.00	
2.00 City, State, Zip Code, County		KANSAS		IL61933		2.00	
1.00							
3.00 FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban						0 3.00	
				Grant Award		Date	
				1.00		2.00	
Source of Federal Funds							
4.00 Community Health Center (Section 330(d), PHS Act)				0		4.00	
5.00 Migrant Health Center (Section 329(d), PHS Act)				0		5.00	
6.00 Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00	
7.00 Appalachian Regional Commission				0		7.00	
8.00 Look-Alikes				0		8.00	
9.00 OTHER (SPECIFY)				0		9.00	
9.01				0		9.01	
9.02				0		9.02	
9.03				0		9.03	
9.04				0		9.04	
9.05				0		9.05	
9.06				0		9.06	
9.07				0		9.07	
9.08				0		9.08	
9.09				0		9.09	
9.10				0		9.10	
1.00							
10.00 Does this facility operate as other than an RHC or FOHC? 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)				08:30 12:00			
Clinic							
1.00							
12.00 Have you received an approval for an exception to the productivity standard?		N				12.00	
13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		N				0 13.00	
				Provider name		CCN number	
				1.00		2.00	
14.00 Provider name, CCN number							
		Y/N		V		XVIII	
		1.00		2.00		3.00	
						XIX	
						4.00	
						Total Visits	
						5.00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		N		0		0 15.00	

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141320 Component CCN: 143431		Period: From 01/01/2014 To 12/31/2014		Worksheet S-8 Date/Time Prepared: 5/18/2015 9:22 am	
				Rural Health Clinic (RHC) III		Cost	
		County 4.00					
2.00	City, State, Zip Code, County	EDGAR				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) Clinic	08:30		12:00		13:30 17:00	
		Friday		Saturday			
		from to		from to			
		11.00 12.00		13.00 14.00			
11.00	Facility hours of operations (1) Clinic						

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Prepared: 5/18/2015 9:22 am
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				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.406248		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		2,997,170		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?		Y		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0		5.00
6.00	Medicaid charges		17,274,252		6.00
7.00	Medicaid cost (line 1 times line 6)		7,017,630		7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		4,020,460		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)		4,020,460		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	524,260	269,903	794,163	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	212,980	109,648	322,628	21.00
22.00	Partial payment by patients approved for charity care	7,889	2,541	10,430	22.00
23.00	Cost of charity care (line 21 minus line 22)	205,091	107,107	312,198	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)		4,318,732		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		600,551		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		3,718,181		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		1,510,504		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		1,822,702		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		5,843,162		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES		Provider CCN: 141320		Period: From 01/01/2014 To 12/31/2014		Worksheet A	
Date/Time Prepared: 5/18/2015 9:22 am							
Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,031,833		1,031,833	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,170,501		1,170,501	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	98,037	3,702,511		3,800,548	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	1,397,920	2,064,504		3,462,424	5.01
5.02	00560	ADMINISTRATIVE	527,510	233,062		760,572	5.02
7.00	00700	OPERATION OF PLANT	366,653	634,637		1,001,290	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	132,635		132,635	8.00
9.00	00900	HOUSEKEEPING	189,987	53,720		243,707	9.00
10.00	01000	DIETARY	379,266	204,893		584,159	10.00
11.00	01100	CAFETERIA	0	0		0	11.00
13.00	01300	NURSING ADMINISTRATION	659,776	78,924		738,700	13.00
15.00	01500	PHARMACY	130,049	1,400,827		1,530,876	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	302,286	47,768		350,054	16.00
17.00	01700	SOCIAL SERVICE	0	45,949		45,949	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,192,204	286,415		1,478,619	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	881,081	1,937,684		2,818,765	50.00
53.00	05300	ANESTHESIOLOGY	520,263	176,273		696,536	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,295,206	738,788		2,033,994	54.00
60.00	06000	LABORATORY	674,261	900,760		1,575,021	60.00
65.00	06500	RESPIRATORY THERAPY	209,321	63,998		273,319	65.00
66.00	06600	PHYSICAL THERAPY	800,959	158,804		959,763	66.00
69.00	06900	ELECTROCARDIOLOGY	0	43,866		43,866	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,296		2,296	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	3,142,648	955,743		4,098,391	88.00
88.01	08801	RURAL HEALTH CLINIC II	261,431	134,480		395,911	88.01
88.02	08802	RURAL HEALTH CLINIC III	116,040	50,506		166,546	88.02
90.00	09000	CLINIC	89,016	45,336		134,352	90.00
90.01	09001	OP CLINIC	579,203	177,149		756,352	90.01
90.02	09002	SENIOR CARE	1,248	443,120		444,368	90.02
90.03	09003	SLEEP LAB	21,950	19,816		41,766	90.03
91.00	09100	EMERGENCY	1,096,004	1,964,769		3,060,773	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		145,298		145,298	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,932,319	19,046,865		33,979,184	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,800,456	552,157		2,352,613	192.00
192.01	19202	OCCUPATIONAL MEDICINE	24,722	12,227		36,949	192.01
200.00		TOTAL (SUM OF LINES 118-199)	16,757,497	19,611,249		36,368,746	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141320

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

Worksheet A
Date/Time Prepared:
5/18/2015 9:22 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-151,452	1,109,738	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-202,817	1,116,075	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,559,936	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-148,989	3,140,666	5.01
5.02	00560	ADMINISTRATIVE	0	759,982	5.02
7.00	00700	OPERATION OF PLANT	0	999,412	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	132,635	8.00
9.00	00900	HOUSEKEEPING	0	243,707	9.00
10.00	01000	DIETARY	0	113,960	10.00
11.00	01100	CAFETERIA	-277,042	193,157	11.00
13.00	01300	NURSING ADMINISTRATION	0	738,700	13.00
15.00	01500	PHARMACY	0	160,699	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,010	344,044	16.00
17.00	01700	SOCIAL SERVICE	0	45,949	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-126,950	1,319,668	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-80,440	1,201,293	50.00
53.00	05300	ANESTHESIOLOGY	-781,333	31,704	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-750,656	1,375,369	54.00
60.00	06000	LABORATORY	0	1,574,952	60.00
65.00	06500	RESPIRATORY THERAPY	0	221,398	65.00
66.00	06600	PHYSICAL THERAPY	0	959,763	66.00
69.00	06900	ELECTROCARDIOLOGY	-43,196	65,107	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-2,096	200	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-148	702,701	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	917,618	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-25,130	1,375,634	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-133,194	3,949,658	88.00
88.01	08801	RURAL HEALTH CLINIC II	-2,690	361,072	88.01
88.02	08802	RURAL HEALTH CLINIC III	-1,110	154,380	88.02
90.00	09000	CLINIC	-15,649	101,215	90.00
90.01	09001	OP CLINIC	-86,758	669,594	90.01
90.02	09002	SENIOR CARE	-3,660	416,735	90.02
90.03	09003	SLEEP LAB	-10,303	31,463	90.03
91.00	09100	EMERGENCY	-1,430,931	1,629,842	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,280,554	29,718,026	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-23,643	2,309,574	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	36,949	192.01
200.00		TOTAL (SUM OF LINES 118-199)	-4,304,197	32,064,549	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - RENTAL EXPENSE					
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	148,391	1.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
TOTALS			0	148,391	
B - CAFETERIA					
1.00	CAFETERIA	11.00	305,277	164,922	1.00
TOTALS			305,277	164,922	
C - EKG					
1.00	ELECTROCARDIOLOGY	69.00	46,949	0	1.00
2.00		0.00	0	0	2.00
TOTALS			46,949	0	
D - PROPERTY INSURANCE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	84,059	1.00
TOTALS			0	84,059	
E - OXYGEN/PATIENT SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	112,650	1.00
2.00		0.00	0	0	2.00
TOTALS			0	112,650	
F - DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,400,764	1.00
2.00		0.00	0	0	2.00
TOTALS			0	1,400,764	
H - TELEPHONE					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33,709	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
TOTALS			0	33,709	
I - STRESS TEST					
1.00	ELECTROCARDIOLOGY	69.00	11,587	5,901	1.00
TOTALS			11,587	5,901	
J - MED SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	590,199	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	917,618	2.00
TOTALS			0	1,507,817	
K - INTEREST EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	145,298	1.00
TOTALS			0	145,298	
L - ANESTHESIA BENEFITS					
1.00	ANESTHESIOLOGY	53.00	0	117,994	1.00
TOTALS			0	117,994	
M - RADIOLOGY BENEFITS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	120,252	1.00
TOTALS			0	120,252	
N - WOUND CARE BENEFITS					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,366	1.00
TOTALS			0	2,366	
500.00	Grand Total: Increases		363,813	3,844,123	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - RENTAL EXPENSE							
1.00		0.00	0	0	10		1.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	39,150	0		3.00
4.00	ADMINISTRATIVE	5.02	0	590	0		4.00
5.00	OPERATION OF PLANT	7.00	0	1,878	0		5.00
9.00	ADULTS & PEDIATRICS	30.00	0	2,610	0		9.00
10.00	OPERATING ROOM	50.00	0	29,215	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	1,493	0		11.00
13.00	LABORATORY	60.00	0	69	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	4,982	0		14.00
15.00	SENIOR CARE	90.02	0	23,973	0		15.00
17.00	RURAL HEALTH CLINIC	88.00	0	5,095	0		17.00
18.00	RURAL HEALTH CLINIC II	88.01	0	19,229	0		18.00
19.00	RURAL HEALTH CLINIC III	88.02	0	8,918	0		19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	11,189	0		20.00
	TOTALS		0	148,391			
B - CAFETERIA							
1.00	DIETARY	10.00	305,277	164,922	0		1.00
	TOTALS		305,277	164,922			
C - EKG							
1.00	ADULTS & PEDIATRICS	30.00	29,391	0	0		1.00
2.00	RESPIRATORY THERAPY	65.00	17,558	0	0		2.00
	TOTALS		46,949	0			
D - PROPERTY INSURANCE							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	84,059	9		1.00
	TOTALS		0	84,059			
E - OXYGEN/PATIENT SUPPLIES							
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	83,269	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	29,381	0		2.00
	TOTALS		0	112,650			
F - DRUGS							
1.00	PHARMACY	15.00	0	1,370,177	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	30,587	0		2.00
	TOTALS		0	1,400,764			
H - TELEPHONE							
1.00		0.00	0	0	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	10,444	0		2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	12,920	0		3.00
4.00	RURAL HEALTH CLINIC III	88.02	0	2,138	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	8,207	0		5.00
	TOTALS		0	33,709			
I - STRESS TEST							
1.00	CLINIC	90.00	11,587	5,901	0		1.00
	TOTALS		11,587	5,901			
J - MED SUPPLIES							
1.00	OPERATING ROOM	50.00	0	1,507,817	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	1,507,817			
K - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	145,298	9		1.00
	TOTALS		0	145,298			
L - ANESTHESIA BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	117,994	0		1.00
	TOTALS		0	117,994			
M - RADIOLOGY BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	120,252	0		1.00
	TOTALS		0	120,252			
N - WOUND CARE BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,366	0		1.00
	TOTALS		0	2,366			
500.00	Grand Total: Decreases		363,813	3,844,123			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141320

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

Worksheet A-7
Part I
Date/Time Prepared:
5/18/2015 9:22 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	41,266	0	0	0	1.00
2.00	Land Improvements	1,827,926	121,646	0	121,646	2.00
3.00	Buildings and Fixtures	22,600,812	251,981	0	251,981	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	13,213,967	1,583,000	0	1,583,000	5.00
6.00	Movable Equipment	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	37,683,971	1,956,627	0	1,956,627	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	37,683,971	1,956,627	0	1,956,627	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	41,266	0			1.00
2.00	Land Improvements	1,949,572	0			2.00
3.00	Buildings and Fixtures	22,852,793	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	14,796,967	0			5.00
6.00	Movable Equipment	0	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	39,640,598	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	39,640,598	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141320

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

Worksheet A-7
Part II
Date/Time Prepared:
5/18/2015 9:22 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,031,833	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,170,501	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,202,334	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1,031,833				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,170,501				2.00
3.00	Total (sum of lines 1-2)	0	2,202,334				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141320

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

Worksheet A-7
Part III
Date/Time Prepared:
5/18/2015 9:22 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,031,833	0	1,031,833	0.468518	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,170,501	0	1,170,501	0.531482	0	2.00
3.00	Total (sum of lines 1-2)	2,202,334	0	2,202,334	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,109,738	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,170,501	148,391	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,280,239	148,391	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,109,738	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-202,817	0	0	0	1,116,075	2.00
3.00	Total (sum of lines 1-2)	-202,817	0	0	0	2,225,813	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141320

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

Worksheet A-8

Date/Time Prepared:
5/18/2015 9:22 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7	Ref.	
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-46,804	NEW CAP REL COSTS-BLDG & FIXT	1.00		9	1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP REL COSTS-MVBLE EQUIP	2.00		0	2.00
3.00 Investment income - other (chapter 2)		0		0.00		0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-6,420	OTHER ADMINISTRATIVE AND GENERAL	5.01		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	-1,806,943				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00		0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0				0	12.00
13.00 Laundry and linen service		0		0.00		0	13.00
14.00 Cafeteria-employees and guests	B	-277,042	CAFETERIA	11.00		0	14.00
15.00 Rental of quarters to employee and others	B	-104,648	NEW CAP REL COSTS-BLDG & FIXT	1.00		9	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-148	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		0	16.00
17.00 Sale of drugs to other than patients	B	-25,130	DRUGS CHARGED TO PATIENTS	73.00		0	17.00
18.00 Sale of medical records and abstracts	B	-6,010	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 - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00		0	26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00		0	27.00
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00			28.00
29.00 Physicians' assistant		0		0.00		0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00			30.00
30.99 Hospice (non-distinct) (see instructions)			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

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	
33.00 PHYSICIAN RECRUITING	A	-14,307	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 33.00
34.00 ADVERTISING	A	-43,053	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 34.00
35.00		0		0.00	0 35.00
36.00 ADVERTISING	A	-18,162	RURAL HEALTH CLINIC	88.00	0 36.00
37.00 ADVERTISING	A	-2,690	RURAL HEALTH CLINIC II	88.01	0 37.00
38.00 ADVERTISING	A	-1,110	RURAL HEALTH CLINIC III	88.02	0 38.00
39.00 ADVERTISING	A	-13,643	PHYSICIANS' PRIVATE OFFICES	192.00	0 39.00
40.00 ANESTHESIA	A	-640,975	ANESTHESIOLOGY	53.00	0 40.00
41.00 ANESTHESIA OTHER	A	-140,358	ANESTHESIOLOGY	53.00	0 41.00
42.00 OTHER REVENUE	B	-34,571	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 42.00
43.00 CPR	B	-9,381	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 43.00
44.00 IHA	A	-14,083	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 44.00
45.00 FMC OTHER REVENUE	B	-115,032	RURAL HEALTH CLINIC	88.00	0 45.00
45.01		0		0.00	0 45.01
45.02		0		0.00	0 45.02
45.03 FMC OTHER REVENUE	B	-10,000	PHYSICIANS' PRIVATE OFFICES	192.00	0 45.03
45.04 AHA	A	-2,918	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 45.04
45.05		0		0.00	0 45.05
45.06 NRHA	A	-101	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 45.06
45.07 RADIOLOGY	A	-615,181	RADIOLOGY-DIAGNOSTIC	54.00	0 45.07
45.08 RADIOLOGY OTHER	A	-135,319	RADIOLOGY-DIAGNOSTIC	54.00	0 45.08
45.09 WOUND CARE	A	-10,434	OP CLINIC	90.01	0 45.09
45.10 WOUND CARE OTHER	A	-2,976	OP CLINIC	90.01	0 45.10
45.11		0		0.00	0 45.11
45.12 MCHC DUES	A	-125	OTHER ADMINISTRATIVE AND GENERAL	5.01	0 45.12
45.13 ADVERTISING	A	-3,660	SENIOR CARE	90.02	0 45.13
45.14 RADIOLOGY REVENUE	B	-156	RADIOLOGY-DIAGNOSTIC	54.00	0 45.14
45.15 MEANINGFUL USE ACCELERATED PAYMENT	A	-202,817	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11 45.15
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,304,197			50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141320

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

Worksheet A-8-2

Date/Time Prepared:
5/18/2015 9:22 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	24,030	24,030	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	126,950	126,950	0	0	0	2.00
3.00	50.00	OPERATING ROOM	80,440	80,440	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	43,196	43,196	0	0	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	2,096	2,096	0	0	0	5.00
6.00	90.00	CLINIC	24,649	15,649	9,000	0	0	6.00
7.00	90.01	OP CLINIC	10,000	0	10,000	0	0	7.00
8.00	90.01	OP CLINIC	73,348	73,348	0	0	0	8.00
9.00	90.02	SENIOR CARE	21,500	0	21,500	0	0	9.00
10.00	90.03	SLEEP LAB	10,303	10,303	0	0	0	10.00
11.00	91.00	EMERGENCY	1,810,703	1,430,931	379,722	0	0	11.00
200.00			2,227,215	1,806,943	420,222			200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.01	OP CLINIC	0	0	0	0	0	7.00
8.00	90.01	OP CLINIC	0	0	0	0	0	8.00
9.00	90.02	SENIOR CARE	0	0	0	0	0	9.00
10.00	90.03	SLEEP LAB	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	24,030	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	126,950	2.00
3.00	50.00	OPERATING ROOM	0	0	0	80,440	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	43,196	4.00
5.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	2,096	5.00
6.00	90.00	CLINIC	0	0	0	15,649	6.00
7.00	90.01	OP CLINIC	0	0	0	0	7.00
8.00	90.01	OP CLINIC	0	0	0	73,348	8.00
9.00	90.02	SENIOR CARE	0	0	0	0	9.00
10.00	90.03	SLEEP LAB	0	0	0	10,303	10.00
11.00	91.00	EMERGENCY	0	0	0	1,430,931	11.00
200.00			0	0	0	1,806,943	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141320

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

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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	1,109,738	1,109,738			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	1,116,075		1,116,075		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	3,559,936	8,288	8,336	3,576,560	4.00
5.01 00590	OTHER ADMINISTRATIVE AND GENERAL	3,140,666	190,058	191,139	320,312	3,842,175 5.01
5.02 00560	ADMINISTRATIVE	759,982	29,398	29,566	120,871	939,817 5.02
7.00 00700	OPERATION OF PLANT	999,412	106,030	106,636	84,013	1,296,091 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	132,635	8,682	8,731	0	150,048 8.00
9.00 00900	HOUSEKEEPING	243,707	6,098	6,133	43,533	299,471 9.00
10.00 01000	DIETARY	113,960	27,431	27,587	16,953	185,931 10.00
11.00 01100	CAFETERIA	193,157	12,482	12,553	69,950	288,142 11.00
13.00 01300	NURSING ADMINISTRATION	738,700	12,338	12,409	151,178	914,625 13.00
15.00 01500	PHARMACY	160,699	7,716	7,760	29,799	205,974 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	344,044	19,947	20,061	69,264	453,316 16.00
17.00 01700	SOCIAL SERVICE	45,949	1,395	1,403	0	48,747 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,319,668	125,790	126,508	266,441	1,838,407 30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,201,293	89,338	89,848	201,886	1,582,365 50.00
53.00 05300	ANESTHESIOLOGY	31,704	1,055	1,061	0	33,820 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,375,369	65,304	65,677	175,285	1,681,635 54.00
60.00 06000	LABORATORY	1,574,952	27,225	27,381	154,497	1,784,055 60.00
65.00 06500	RESPIRATORY THERAPY	221,398	3,371	3,390	43,940	272,099 65.00
66.00 06600	PHYSICAL THERAPY	959,763	39,322	39,547	183,528	1,222,160 66.00
69.00 06900	ELECTROCARDIOLOGY	65,107	4,676	4,703	13,413	87,899 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	200	2,754	2,770	0	5,724 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	702,701	0	0	0	702,701 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	917,618	0	0	0	917,618 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,375,634	0	0	0	1,375,634 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	3,949,658	164,245	165,183	720,086	4,999,172 88.00
88.01 08801	RURAL HEALTH CLINIC II	361,072	13,411	13,488	59,903	447,874 88.01
88.02 08802	RURAL HEALTH CLINIC III	154,380	6,911	6,951	26,589	194,831 88.02
90.00 09000	CLINIC	101,215	5,490	5,521	17,742	129,968 90.00
90.01 09001	OP CLINIC	669,594	11,051	11,114	132,716	824,475 90.01
90.02 09002	SENIOR CARE	416,735	14,305	14,387	286	445,713 90.02
90.03 09003	SLEEP LAB	31,463	1,162	1,169	5,030	38,824 90.03
91.00 09100	EMERGENCY	1,629,842	45,983	46,246	251,133	1,973,204 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00 11800	SUBTOTALS (SUM OF LINES 1-117)	29,718,026	1,051,256	1,057,258	3,158,348	29,182,515 118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,309,574	39,304	39,529	412,547	2,800,954 192.00
192.01 19201	OCCUPATIONAL MEDICINE	36,949	19,178	19,288	5,665	81,080 192.01
200.00	Cross Foot Adjustments		0	0	0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	32,064,549	1,109,738	1,116,075	3,576,560	32,064,549 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141320

Period:
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Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.01	ADMINITTING 5.02	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	3,842,175				5.01
5.02	00560	ADMINITTING	127,946	1,067,763			5.02
7.00	00700	OPERATION OF PLANT	176,449	0	1,472,540		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,427	0	16,475	186,950	8.00
9.00	00900	HOUSEKEEPING	40,770	0	11,572	0	351,813
10.00	01000	DIETARY	25,312	0	52,055	0	12,678
11.00	01100	CAFETERIA	39,227	0	23,686	0	5,769
13.00	01300	NURSING ADMINISTRATION	124,516	0	23,415	0	5,703
15.00	01500	PHARMACY	28,041	0	14,643	0	3,566
16.00	01600	MEDICAL RECORDS & LIBRARY	61,714	0	37,854	0	9,219
17.00	01700	SOCIAL SERVICE	6,636	0	2,647	0	645
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	250,279	131,509	238,710	186,950	58,139
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	215,422	113,193	169,535	0	41,291
53.00	05300	ANESTHESIOLOGY	4,604	2,419	2,002	0	488
54.00	05400	RADIOLOGY-DIAGNOSTIC	228,936	120,294	123,928	0	30,183
60.00	06000	LABORATORY	242,879	127,621	51,665	0	12,583
65.00	06500	RESPIRATORY THERAPY	37,043	19,464	6,397	0	1,558
66.00	06600	PHYSICAL THERAPY	166,384	87,426	74,621	0	18,174
69.00	06900	ELECTROCARDIOLOGY	11,966	6,288	8,874	0	2,161
70.00	07000	ELECTROENCEPHALOGRAPHY	779	409	5,226	0	1,273
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	95,665	50,267	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	124,924	65,641	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	187,277	98,405	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	680,594	0	311,683	0	75,913
88.01	08801	RURAL HEALTH CLINIC II	60,973	0	25,451	0	6,199
88.02	08802	RURAL HEALTH CLINIC III	26,524	0	13,116	0	3,194
90.00	09000	CLINIC	17,694	9,297	10,418	0	2,537
90.01	09001	OP CLINIC	112,243	58,978	20,971	0	5,108
90.02	09002	SENIOR CARE	60,679	31,884	27,147	0	6,612
90.03	09003	SLEEP LAB	5,285	3,514	2,206	0	537
91.00	09100	EMERGENCY	268,630	141,154	87,262	0	21,253
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,449,818	1,067,763	1,361,559	186,950	324,783
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	381,319	0	74,587	0	18,166
192.01	19202	OCCUPATIONAL MEDICINE	11,038	0	36,394	0	8,864
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	3,842,175	1,067,763	1,472,540	186,950	351,813

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141320

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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
		10.00	11.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00590						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	275,976					10.00
11.00	01100	0	356,824				11.00
13.00	01300	0	18,468	1,086,727			13.00
15.00	01500	0	3,640	0	255,864		15.00
16.00	01600	0	8,461	0	0	570,564	16.00
17.00	01700	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	275,976	32,548	333,618	48	19,351	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	24,662	258,340	24	61,515	50.00
53.00	05300	0	0	0	22	9,494	53.00
54.00	05400	0	21,413	0	126	149,918	54.00
60.00	06000	0	18,873	0	0	105,678	60.00
65.00	06500	0	5,368	0	207	4,988	65.00
66.00	06600	0	22,420	0	208	60,019	66.00
69.00	06900	0	1,638	0	0	9,312	69.00
70.00	07000	0	0	0	9	115	70.00
71.00	07100	0	0	0	0	45,653	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	234,537	45,061	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	87,972	0	14,246	0	88.00
88.01	08801	0	7,318	0	2,505	0	88.01
88.02	08802	0	3,248	0	855	0	88.02
90.00	09000	0	2,167	0	13	993	90.00
90.01	09001	0	16,212	171,249	44	6,822	90.01
90.02	09002	0	35	187	0	5,328	90.02
90.03	09003	0	614	0	0	1,099	90.03
91.00	09100	0	30,678	323,333	83	45,218	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		275,976	305,735	1,086,727	252,927	570,564	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	50,397	0	2,918	0	192.00
192.01	19202	0	692	0	19	0	192.01
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		275,976	356,824	1,086,727	255,864	570,564	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141320

Period:
From 01/01/2014
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00560	ADMITTING					5.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	58,675				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	58,675	3,424,210	0	3,424,210	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,466,347	0	2,466,347	50.00
53.00	05300	ANESTHESIOLOGY	0	52,849	0	52,849	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,356,433	0	2,356,433	54.00
60.00	06000	LABORATORY	0	2,343,354	0	2,343,354	60.00
65.00	06500	RESPIRATORY THERAPY	0	347,124	0	347,124	65.00
66.00	06600	PHYSICAL THERAPY	0	1,651,412	0	1,651,412	66.00
69.00	06900	ELECTROCARDIOLOGY	0	128,138	0	128,138	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,535	0	13,535	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	894,286	0	894,286	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,108,183	0	1,108,183	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,940,914	0	1,940,914	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	6,169,580	0	6,169,580	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	550,320	0	550,320	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	241,768	0	241,768	88.02
90.00	09000	CLINIC	0	173,087	0	173,087	90.00
90.01	09001	OP CLINIC	0	1,216,102	0	1,216,102	90.01
90.02	09002	SENIOR CARE	0	577,585	0	577,585	90.02
90.03	09003	SLEEP LAB	0	52,079	0	52,079	90.03
91.00	09100	EMERGENCY	0	2,890,815	0	2,890,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,675	28,598,121	0	28,598,121	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,328,341	0	3,328,341	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	138,087	0	138,087	192.01
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	58,675	32,064,549	0	32,064,549	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141320

Period:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,288	8,336	16,624	4.00
5.01 00590	OTHER ADMINISTRATIVE AND GENERAL	0	190,058	191,139	381,197	5.01
5.02 00560	ADMINISTRATIVE	0	29,398	29,566	58,964	5.02
7.00 00700	OPERATION OF PLANT	0	106,030	106,636	212,666	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	8,682	8,731	17,413	8.00
9.00 00900	HOUSEKEEPING	0	6,098	6,133	12,231	9.00
10.00 01000	DIETARY	0	27,431	27,587	55,018	10.00
11.00 01100	CAFETERIA	0	12,482	12,553	25,035	11.00
13.00 01300	NURSING ADMINISTRATION	0	12,338	12,409	24,747	13.00
15.00 01500	PHARMACY	0	7,716	7,760	15,476	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	19,947	20,061	40,008	16.00
17.00 01700	SOCIAL SERVICE	0	1,395	1,403	2,798	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	125,790	126,508	252,298	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	89,338	89,848	179,186	50.00
53.00 05300	ANESTHESIOLOGY	0	1,055	1,061	2,116	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	65,304	65,677	130,981	54.00
60.00 06000	LABORATORY	0	27,225	27,381	54,606	60.00
65.00 06500	RESPIRATORY THERAPY	0	3,371	3,390	6,761	65.00
66.00 06600	PHYSICAL THERAPY	0	39,322	39,547	78,869	66.00
69.00 06900	ELECTROCARDIOLOGY	0	4,676	4,703	9,379	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	2,754	2,770	5,524	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	164,245	165,183	329,428	88.00
88.01 08801	RURAL HEALTH CLINIC II	0	13,411	13,488	26,899	88.01
88.02 08802	RURAL HEALTH CLINIC III	0	6,911	6,951	13,862	88.02
90.00 09000	CLINIC	0	5,490	5,521	11,011	90.00
90.01 09001	OP CLINIC	0	11,051	11,114	22,165	90.01
90.02 09002	SENIOR CARE	0	14,305	14,387	28,692	90.02
90.03 09003	SLEEP LAB	0	1,162	1,169	2,331	90.03
91.00 09100	EMERGENCY	0	45,983	46,246	92,229	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	1,051,256	1,057,258	2,108,514	118.00
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	39,304	39,529	78,833	192.00
192.01 19202	OCCUPATIONAL MEDICINE	0	19,178	19,288	38,466	192.01
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,109,738	1,116,075	2,225,813	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141320

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

Worksheet B
Part II
Date/Time Prepared:
5/18/2015 9:22 am

Cost Center Description		OTHER ADMINISTRATIVE AND GENERAL 5.01	ADMINITTING 5.02	OPERATION OF PLANT 7.00	LAUNDRY & LINEN SERVICE 8.00	HOUSEKEEPING 9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00590	382,686					5.01
5.02	00560	12,744	72,270				5.02
7.00	00700	17,575	0	230,631			7.00
8.00	00800	2,035	0	2,580	22,028		8.00
9.00	00900	4,061	0	1,812	0	18,306	9.00
10.00	01000	2,521	0	8,153	0	660	10.00
11.00	01100	3,907	0	3,710	0	300	11.00
13.00	01300	12,402	0	3,667	0	297	13.00
15.00	01500	2,793	0	2,293	0	186	15.00
16.00	01600	6,147	0	5,929	0	480	16.00
17.00	01700	661	0	415	0	34	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	24,929	8,902	37,387	22,028	3,025	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	21,457	7,662	26,553	0	2,149	50.00
53.00	05300	459	164	314	0	25	53.00
54.00	05400	22,803	8,142	19,410	0	1,571	54.00
60.00	06000	24,192	8,638	8,092	0	655	60.00
65.00	06500	3,690	1,318	1,002	0	81	65.00
66.00	06600	16,572	5,918	11,687	0	946	66.00
69.00	06900	1,192	426	1,390	0	112	69.00
70.00	07000	78	28	818	0	66	70.00
71.00	07100	9,529	3,402	0	0	0	71.00
72.00	07200	12,443	4,443	0	0	0	72.00
73.00	07300	18,654	6,661	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	67,778	0	48,816	0	3,948	88.00
88.01	08801	6,073	0	3,986	0	323	88.01
88.02	08802	2,642	0	2,054	0	166	88.02
90.00	09000	1,762	629	1,632	0	132	90.00
90.01	09001	11,180	3,992	3,285	0	266	90.01
90.02	09002	6,044	2,158	4,252	0	344	90.02
90.03	09003	526	238	345	0	28	90.03
91.00	09100	26,757	9,549	13,667	0	1,106	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		343,606	72,270	213,249	22,028	16,900	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	37,981	0	11,682	0	945	192.00
192.01	19202	1,099	0	5,700	0	461	192.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		382,686	72,270	230,631	22,028	18,306	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 141320		Period: From 01/01/2014 To 12/31/2014		Worksheet B Part II Date/Time Prepared: 5/18/2015 9:22 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	66,431					10.00
11.00	01100	CAFETERIA	0	33,277				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,722	43,538			13.00
15.00	01500	PHARMACY	0	339	0	21,226		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	789	0	0	53,675	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	66,431	3,035	13,365	4	1,821	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,300	10,350	2	5,790	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2	894	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,997	0	10	14,083	54.00
60.00	06000	LABORATORY	0	1,760	0	0	9,947	60.00
65.00	06500	RESPIRATORY THERAPY	0	501	0	17	469	65.00
66.00	06600	PHYSICAL THERAPY	0	2,091	0	17	5,649	66.00
69.00	06900	ELECTROCARDIOLOGY	0	153	0	0	877	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1	11	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,297	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	19,456	4,241	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	8,206	0	1,182	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	682	0	208	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	303	0	71	0	88.02
90.00	09000	CLINIC	0	202	0	1	93	90.00
90.01	09001	OP CLINIC	0	1,512	6,861	4	642	90.01
90.02	09002	SENIOR CARE	0	3	8	0	502	90.02
90.03	09003	SLEEP LAB	0	57	0	0	103	90.03
91.00	09100	EMERGENCY	0	2,861	12,954	7	4,256	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)	66,431	28,513	43,538	20,982	53,675	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,699	0	242	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	65	0	2	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	66,431	33,277	43,538	21,226	53,675	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141320

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

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Part II
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Cost Center Description			SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00560	ADMITTING					5.02
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE	3,908				17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	3,908	438,371	0	438,371	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	256,387	0	256,387	50.00
53.00	05300	ANESTHESIOLOGY	0	3,974	0	3,974	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	199,812	0	199,812	54.00
60.00	06000	LABORATORY	0	108,608	0	108,608	60.00
65.00	06500	RESPIRATORY THERAPY	0	14,043	0	14,043	65.00
66.00	06600	PHYSICAL THERAPY	0	122,602	0	122,602	66.00
69.00	06900	ELECTROCARDIOLOGY	0	13,591	0	13,591	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,526	0	6,526	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	17,228	0	17,228	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	16,886	0	16,886	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	49,012	0	49,012	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	462,708	0	462,708	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	38,449	0	38,449	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	19,222	0	19,222	88.02
90.00	09000	CLINIC	0	15,544	0	15,544	90.00
90.01	09001	OP CLINIC	0	50,524	0	50,524	90.01
90.02	09002	SENIOR CARE	0	42,004	0	42,004	90.02
90.03	09003	SLEEP LAB	0	3,651	0	3,651	90.03
91.00	09100	EMERGENCY	0	164,553	0	164,553	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0		0		92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,908	2,043,695	0	2,043,695	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	136,299	0	136,299	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	45,819	0	45,819	192.01
200.00		Cross Foot Adjustments		0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,908	2,225,813	0	2,225,813	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141320

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

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Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	124,119						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		124,119					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	927	927	15,608,976				4.00
5.01 00590 OTHER ADMINISTRATIVE AND GENERAL	21,257	21,257	1,397,920	-3,842,175	28,222,374		5.01
5.02 00560 ADMITTING	3,288	3,288	527,510	0	939,817		5.02
7.00 00700 OPERATION OF PLANT	11,859	11,859	366,653	0	1,296,091		7.00
8.00 00800 LAUNDRY & LINEN SERVICE	971	971	0	0	150,048		8.00
9.00 00900 HOUSEKEEPING	682	682	189,987	0	299,471		9.00
10.00 01000 DIETARY	3,068	3,068	73,989	0	185,931		10.00
11.00 01100 CAFETERIA	1,396	1,396	305,277	0	288,142		11.00
13.00 01300 NURSING ADMINISTRATION	1,380	1,380	659,776	0	914,625		13.00
15.00 01500 PHARMACY	863	863	130,049	0	205,974		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	2,231	2,231	302,286	0	453,316		16.00
17.00 01700 SOCIAL SERVICE	156	156	0	0	48,747		17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	14,069	14,069	1,162,812	0	1,838,407		30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	9,992	9,992	881,081	0	1,582,365		50.00
53.00 05300 ANESTHESIOLOGY	118	118	0	0	33,820		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	7,304	7,304	764,986	0	1,681,635		54.00
60.00 06000 LABORATORY	3,045	3,045	674,261	0	1,784,055		60.00
65.00 06500 RESPIRATORY THERAPY	377	377	191,763	0	272,099		65.00
66.00 06600 PHYSICAL THERAPY	4,398	4,398	800,959	0	1,222,160		66.00
69.00 06900 ELECTROCARDIOLOGY	523	523	58,536	0	87,899		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	308	308	0	0	5,724		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	702,701		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	917,618		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	1,375,634		73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	18,370	18,370	3,142,648	0	4,999,172		88.00
88.01 08801 RURAL HEALTH CLINIC II	1,500	1,500	261,431	0	447,874		88.01
88.02 08802 RURAL HEALTH CLINIC III	773	773	116,040	0	194,831		88.02
90.00 09000 CLINIC	614	614	77,429	0	129,968		90.00
90.01 09001 OP CLINIC	1,236	1,236	579,203	0	824,475		90.01
90.02 09002 SENIOR CARE	1,600	1,600	1,248	0	445,713		90.02
90.03 09003 SLEEP LAB	130	130	21,950	0	38,824		90.03
91.00 09100 EMERGENCY	5,143	5,143	1,096,004	0	1,973,204		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 11800 SUBTOTALS (SUM OF LINES 1-117)	117,578	117,578	13,783,798	-3,842,175	25,340,340		118.00
NONREIMBURSABLE COST CENTERS							
192.00 19200 PHYSICIANS' PRIVATE OFFICES	4,396	4,396	1,800,456	0	2,800,954		192.00
192.01 19202 OCCUPATIONAL MEDICINE	2,145	2,145	24,722	0	81,080		192.01
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)	1,109,738	1,116,075	3,576,560	3,842,175		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8.940920	8.991975	0.229135	0.136139		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			16,624	382,686		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001065	0.013560		205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141320

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		ADMINISTRATIVE (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
		5.02	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL					5.01
5.02	00560	ADMINISTRATIVE	14,926,604				5.02
7.00	00700	OPERATION OF PLANT	0	86,788			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	971	100		8.00
9.00	00900	HOUSEKEEPING	0	682	0	85,135	9.00
10.00	01000	DIETARY	0	3,068	0	3,068	10.00
11.00	01100	CAFETERIA	0	1,396	0	1,396	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,380	0	1,380	13.00
15.00	01500	PHARMACY	0	863	0	863	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,231	0	2,231	16.00
17.00	01700	SOCIAL SERVICE	0	156	0	156	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,838,407	14,069	100	14,069	100
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,582,365	9,992	0	9,992	0
53.00	05300	ANESTHESIOLOGY	33,820	118	0	118	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,681,635	7,304	0	7,304	0
60.00	06000	LABORATORY	1,784,055	3,045	0	3,045	0
65.00	06500	RESPIRATORY THERAPY	272,099	377	0	377	0
66.00	06600	PHYSICAL THERAPY	1,222,160	4,398	0	4,398	0
69.00	06900	ELECTROCARDIOLOGY	87,899	523	0	523	0
70.00	07000	ELECTROENCEPHALOGRAPHY	5,724	308	0	308	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	702,701	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	917,618	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,375,634	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	18,370	0	18,370	0
88.01	08801	RURAL HEALTH CLINIC II	0	1,500	0	1,500	0
88.02	08802	RURAL HEALTH CLINIC III	0	773	0	773	0
90.00	09000	CLINIC	129,968	614	0	614	0
90.01	09001	OP CLINIC	824,475	1,236	0	1,236	0
90.02	09002	SENIOR CARE	445,713	1,600	0	1,600	0
90.03	09003	SLEEP LAB	49,127	130	0	130	0
91.00	09100	EMERGENCY	1,973,204	5,143	0	5,143	0
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)	14,926,604	80,247	100	78,594	100
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,396	0	4,396	0
192.01	19202	OCCUPATIONAL MEDICINE	0	2,145	0	2,145	0
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)	1,067,763	1,472,540	186,950	351,813	275,976
203.00		Unit cost multiplier (Wkst. B, Part I)	0.071534	16.967092	1,869.500000	4.132413	2,759.760000
204.00		Cost to be allocated (per Wkst. B, Part II)	72,270	230,631	22,028	18,306	66,431
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004842	2.657407	220.280000	0.215023	664.310000

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141320

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

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Cost Center Description		CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NRSNG SALARIES)	PHARMACY (COST REQU.)	MEDICAL RECORDS & LIBRARY (GROSS REV)	SOCIAL SERVICE (PAT DAYS)	
		11.00	13.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00590						5.01
5.02	00560						5.02
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	12,747,640					11.00
13.00	01300	659,776	3,273,736				13.00
15.00	01500	130,049	0	1,494,778			15.00
16.00	01600	302,286	0	0	64,089,470		16.00
17.00	01700	0	0	0	0	100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,162,812	1,005,013	282	2,173,575	100	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	881,081	778,244	143	6,909,428	0	50.00
53.00	05300	0	0	128	1,066,354	0	53.00
54.00	05400	764,986	0	738	16,842,012	0	54.00
60.00	06000	674,261	0	0	11,869,887	0	60.00
65.00	06500	191,763	0	1,211	560,213	0	65.00
66.00	06600	800,959	0	1,215	6,741,385	0	66.00
69.00	06900	58,536	0	0	1,045,958	0	69.00
70.00	07000	0	0	55	12,929	0	70.00
71.00	07100	0	0	0	5,127,799	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	1,370,177	5,061,291	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	3,142,648	0	83,227	0	0	88.00
88.01	08801	261,431	0	14,632	0	0	88.01
88.02	08802	116,040	0	4,993	0	0	88.02
90.00	09000	77,429	0	74	111,511	0	90.00
90.01	09001	579,203	515,884	259	766,261	0	90.01
90.02	09002	1,248	564	0	598,505	0	90.02
90.03	09003	21,950	0	0	123,400	0	90.03
91.00	09100	1,096,004	974,031	485	5,078,962	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		10,922,462	3,273,736	1,477,619	64,089,470	100	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	1,800,456	0	17,047	0	0	192.00
192.01	19202	24,722	0	112	0	0	192.01
200.00							200.00
201.00							201.00
202.00		356,824	1,086,727	255,864	570,564	58,675	202.00
203.00		0.027991	0.331953	0.171172	0.008903	586.750000	203.00
204.00		33,277	43,538	21,226	53,675	3,908	204.00
205.00		0.002610	0.013299	0.014200	0.000838	39.080000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141320

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

Worksheet C
Part I
Date/Time Prepared:
5/18/2015 9:22 am

Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	3,424,210		3,424,210	0	0	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,466,347		2,466,347	0	0	50.00
53.00	05300 ANESTHESIOLOGY	52,849		52,849	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,356,433		2,356,433	0	0	54.00
60.00	06000 LABORATORY	2,343,354		2,343,354	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	347,124	0	347,124	0	0	65.00
66.00	06600 PHYSICAL THERAPY	1,651,412	0	1,651,412	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	128,138		128,138	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	13,535		13,535	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	894,286		894,286	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,108,183		1,108,183	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,940,914		1,940,914	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	6,169,580		6,169,580	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	550,320		550,320	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	241,768		241,768	0	0	88.02
90.00	09000 CLINIC	173,087		173,087	0	0	90.00
90.01	09001 OP CLINIC	1,216,102		1,216,102	0	0	90.01
90.02	09002 SENIOR CARE	577,585		577,585	0	0	90.02
90.03	09003 SLEEP LAB	52,079		52,079	0	0	90.03
91.00	09100 EMERGENCY	2,890,815		2,890,815	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	209,086		209,086	0	0	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	28,807,207	0	28,807,207	0	0	200.00
201.00	Less Observation Beds	209,086		209,086			201.00
202.00	Total (see instructions)	28,598,121	0	28,598,121	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141320

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

Worksheet C
Part I
Date/Time Prepared:
5/18/2015 9:22 am

		Title XVIII			Hospital	Cost		
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,981,896		1,981,896			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,248,162	5,661,266	6,909,428	0.356954	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	211,503	854,851	1,066,354	0.049560	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	592,898	16,249,114	16,842,012	0.139914	0.000000	54.00
60.00	06000	LABORATORY	686,334	11,183,554	11,869,888	0.197420	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	408,202	152,011	560,213	0.619629	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,178,452	5,562,933	6,741,385	0.244966	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	20,519	1,025,439	1,045,958	0.122508	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	12,929	12,929	1.046871	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	974,744	2,088,615	3,063,359	0.291930	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,484,457	579,983	2,064,440	0.536796	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,133,523	3,927,769	5,061,292	0.383482	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	5,907,484	5,907,484			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	301,302	301,302			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	97,382	97,382			88.02
90.00	09000	CLINIC	0	111,511	111,511	1.552197	0.000000	90.00
90.01	09001	OP CLINIC	246	766,015	766,261	1.587060	0.000000	90.01
90.02	09002	SENIOR CARE	0	598,505	598,505	0.965046	0.000000	90.02
90.03	09003	SLEEP LAB	0	123,400	123,400	0.422034	0.000000	90.03
91.00	09100	EMERGENCY	80,747	4,998,216	5,078,963	0.569174	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,226	187,453	191,679	1.090813	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,005,909	60,389,732	70,395,641			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,005,909	60,389,732	70,395,641			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141320

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

Worksheet C
Part I
Date/Time Prepared:
5/18/2015 9:22 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC				88.00
88.01	08801 RURAL HEALTH CLINIC II				88.01
88.02	08802 RURAL HEALTH CLINIC III				88.02
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 OP CLINIC	0.000000			90.01
90.02	09002 SENIOR CARE	0.000000			90.02
90.03	09003 SLEEP LAB	0.000000			90.03
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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141320

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

Worksheet C
Part I
Date/Time Prepared:
5/18/2015 9:22 am

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	3,424,210		3,424,210	0	3,424,210	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	2,466,347		2,466,347	0	2,466,347	50.00
53.00	05300 ANESTHESIOLOGY	52,849		52,849	0	52,849	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	2,356,433		2,356,433	0	2,356,433	54.00
60.00	06000 LABORATORY	2,343,354		2,343,354	0	2,343,354	60.00
65.00	06500 RESPIRATORY THERAPY	347,124	0	347,124	0	347,124	65.00
66.00	06600 PHYSICAL THERAPY	1,651,412	0	1,651,412	0	1,651,412	66.00
69.00	06900 ELECTROCARDIOLOGY	128,138		128,138	0	128,138	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	13,535		13,535	0	13,535	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	894,286		894,286	0	894,286	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1,108,183		1,108,183	0	1,108,183	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,940,914		1,940,914	0	1,940,914	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	6,169,580		6,169,580	0	6,169,580	88.00
88.01	08801 RURAL HEALTH CLINIC II	550,320		550,320	0	550,320	88.01
88.02	08802 RURAL HEALTH CLINIC III	241,768		241,768	0	241,768	88.02
90.00	09000 CLINIC	173,087		173,087	0	173,087	90.00
90.01	09001 OP CLINIC	1,216,102		1,216,102	0	1,216,102	90.01
90.02	09002 SENIOR CARE	577,585		577,585	0	577,585	90.02
90.03	09003 SLEEP LAB	52,079		52,079	0	52,079	90.03
91.00	09100 EMERGENCY	2,890,815		2,890,815	0	2,890,815	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	209,086		209,086	0	209,086	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	28,807,207	0	28,807,207	0	28,807,207	200.00
201.00	Less Observation Beds	209,086		209,086		209,086	201.00
202.00	Total (see instructions)	28,598,121	0	28,598,121	0	28,598,121	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141320

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

Worksheet C
Part I
Date/Time Prepared:
5/18/2015 9:22 am

		Title XIX			Hospital	Cost		
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio			
	Inpatient	Outpatient	Total (col. 6 + col. 7)					
	6.00	7.00	8.00				9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,981,896		1,981,896			30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,248,162	5,661,266	6,909,428	0.356954	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	211,503	854,851	1,066,354	0.049560	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	592,898	16,249,114	16,842,012	0.139914	0.000000	54.00
60.00	06000	LABORATORY	686,334	11,183,554	11,869,888	0.197420	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	408,202	152,011	560,213	0.619629	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,178,452	5,562,933	6,741,385	0.244966	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	20,519	1,025,439	1,045,958	0.122508	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	12,929	12,929	1.046871	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	974,744	2,088,615	3,063,359	0.291930	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,484,457	579,983	2,064,440	0.536796	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,133,523	3,927,769	5,061,292	0.383482	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	5,907,484	5,907,484	1.044367	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	301,302	301,302	1.826473	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	97,382	97,382	2.482676	0.000000	88.02
90.00	09000	CLINIC	0	111,511	111,511	1.552197	0.000000	90.00
90.01	09001	OP CLINIC	246	766,015	766,261	1.587060	0.000000	90.01
90.02	09002	SENIOR CARE	0	598,505	598,505	0.965046	0.000000	90.02
90.03	09003	SLEEP LAB	0	123,400	123,400	0.422034	0.000000	90.03
91.00	09100	EMERGENCY	80,747	4,998,216	5,078,963	0.569174	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,226	187,453	191,679	1.090813	0.000000	92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,005,909	60,389,732	70,395,641			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,005,909	60,389,732	70,395,641			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141320

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

Worksheet C
Part I
Date/Time Prepared:
5/18/2015 9:22 am

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.000000			50.00
53.00	05300 ANESTHESIOLOGY	0.000000			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000			54.00
60.00	06000 LABORATORY	0.000000			60.00
65.00	06500 RESPIRATORY THERAPY	0.000000			65.00
66.00	06600 PHYSICAL THERAPY	0.000000			66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000			88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000			88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000			88.02
90.00	09000 CLINIC	0.000000			90.00
90.01	09001 OP CLINIC	0.000000			90.01
90.02	09002 SENIOR CARE	0.000000			90.02
90.03	09003 SLEEP LAB	0.000000			90.03
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: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Prepared: 5/18/2015 9:22 am
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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	256,387	6,909,428	0.037107	662,646	24,589	50.00
53.00	05300 ANESTHESIOLOGY	3,974	1,066,354	0.003727	111,654	416	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	199,812	16,842,012	0.011864	282,106	3,347	54.00
60.00	06000 LABORATORY	108,608	11,869,888	0.009150	359,049	3,285	60.00
65.00	06500 RESPIRATORY THERAPY	14,043	560,213	0.025067	130,002	3,259	65.00
66.00	06600 PHYSICAL THERAPY	122,602	6,741,385	0.018186	256,091	4,657	66.00
69.00	06900 ELECTROCARDIOLOGY	13,591	1,045,958	0.012994	9,224	120	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	6,526	12,929	0.504757	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17,228	3,063,359	0.005624	474,758	2,670	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	16,886	2,064,440	0.008179	756,296	6,186	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	49,012	5,061,292	0.009684	547,447	5,301	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	462,708	5,907,484	0.078326	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	38,449	301,302	0.127610	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	19,222	97,382	0.197388	0	0	88.02
90.00	09000 CLINIC	15,544	111,511	0.139394	0	0	90.00
90.01	09001 OP CLINIC	50,524	766,261	0.065936	246	16	90.01
90.02	09002 SENIOR CARE	42,004	598,505	0.070182	0	0	90.02
90.03	09003 SLEEP LAB	3,651	123,400	0.029587	0	0	90.03
91.00	09100 EMERGENCY	164,553	5,078,963	0.032399	2,065	67	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	44,361	191,679	0.231434	0	0	92.00
200.00	Total (lines 50-199)	1,649,685	68,413,745		3,591,584	53,913	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141320

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

Worksheet D
Part IV
Date/Time Prepared:
5/18/2015 9:22 am

Cost Center Description		Title XVIII				Hospital		Total Cost (sum of col 1 through col. 4)	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Cost			
		1.00	2.00	3.00	4.00	5.00			
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	OP CLINIC	0	0	0	0	0	0	90.01
90.02	09002	SENIOR CARE	0	0	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141320

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

Worksheet D
Part IV
Date/Time Prepared:
5/18/2015 9:22 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Cost
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	6,909,428	0.000000	0.000000	662,646	50.00
53.00	05300 ANESTHESIOLOGY	0	1,066,354	0.000000	0.000000	111,654	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	16,842,012	0.000000	0.000000	282,106	54.00
60.00	06000 LABORATORY	0	11,869,888	0.000000	0.000000	359,049	60.00
65.00	06500 RESPIRATORY THERAPY	0	560,213	0.000000	0.000000	130,002	65.00
66.00	06600 PHYSICAL THERAPY	0	6,741,385	0.000000	0.000000	256,091	66.00
69.00	06900 ELECTROCARDIOLOGY	0	1,045,958	0.000000	0.000000	9,224	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	12,929	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,063,359	0.000000	0.000000	474,758	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	2,064,440	0.000000	0.000000	756,296	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5,061,292	0.000000	0.000000	547,447	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	5,907,484	0.000000	0.000000	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	301,302	0.000000	0.000000	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0	97,382	0.000000	0.000000	0	88.02
90.00	09000 CLINIC	0	111,511	0.000000	0.000000	0	90.00
90.01	09001 OP CLINIC	0	766,261	0.000000	0.000000	246	90.01
90.02	09002 SENIOR CARE	0	598,505	0.000000	0.000000	0	90.02
90.03	09003 SLEEP LAB	0	123,400	0.000000	0.000000	0	90.03
91.00	09100 EMERGENCY	0	5,078,963	0.000000	0.000000	2,065	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	191,679	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	68,413,745			3,591,584	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141320

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

Worksheet D
Part IV
Date/Time Prepared:
5/18/2015 9:22 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	Cost
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0	0		88.02
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 OP CLINIC	0	0	0		90.01
90.02	09002 SENIOR CARE	0	0	0		90.02
90.03	09003 SLEEP LAB	0	0	0		90.03
91.00	09100 EMERGENCY	0	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141320

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

Worksheet D
Part V
Date/Time Prepared:
5/18/2015 9:22 am

		Title XVIII		Hospital		Cost		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.356954	0	1,568,853	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.049560	0	221,367	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.139914	0	4,704,013	0	0	54.00
60.00	06000	LABORATORY	0.197420	0	3,915,340	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.619629	0	44,016	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.244966	0	1,815,508	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.122508	0	357,831	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.046871	0	2,951	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.291930	0	589,211	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.536796	0	163,413	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.383482	0	1,571,951	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	1.552197	0	34,595	0	0	90.00
90.01	09001	OP CLINIC	1.587060	0	196,074	40	0	90.01
90.02	09002	SENIOR CARE	0.965046	0	589,986	0	0	90.02
90.03	09003	SLEEP LAB	0.422034	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.569174	0	1,241,475	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.090813	0	50,880	0	0	92.00
200.00		Subtotal (see instructions)		0	17,067,464	40	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	17,067,464	40	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141320

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

Worksheet D
Part V
Date/Time Prepared:
5/18/2015 9:22 am

Cost Center Description		Costs		Hospital	Cost
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	560,008	0		50.00
53.00	05300 ANESTHESIOLOGY	10,971	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	658,157	0		54.00
60.00	06000 LABORATORY	772,966	0		60.00
65.00	06500 RESPIRATORY THERAPY	27,274	0		65.00
66.00	06600 PHYSICAL THERAPY	444,738	0		66.00
69.00	06900 ELECTROCARDIOLOGY	43,837	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	3,089	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	172,008	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	87,719	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	602,815	0		73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0	0		88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000 CLINIC	53,698	0		90.00
90.01	09001 OP CLINIC	311,181	63		90.01
90.02	09002 SENIOR CARE	569,364	0		90.02
90.03	09003 SLEEP LAB	0	0		90.03
91.00	09100 EMERGENCY	706,615	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	55,501	0		92.00
200.00	Subtotal (see instructions)	5,079,941	63		200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00	Net Charges (line 200 +/- line 201)	5,079,941	63		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141320

Period:

Worksheet D

Component CCN: 14Z320

From 01/01/2014

Part V

To 12/31/2014

Date/Time Prepared:

5/18/2015 9:22 am

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.356954	0	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.049560	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.139914	0	0	0	54.00
60.00	06000 LABORATORY	0.197420	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.619629	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.244966	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.122508	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.046871	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.291930	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.536796	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.383482	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000				88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000				88.02
90.00	09000 CLINIC	1.552197	0	0	0	90.00
90.01	09001 OP CLINIC	1.587060	0	0	0	90.01
90.02	09002 SENIOR CARE	0.965046	0	0	0	90.02
90.03	09003 SLEEP LAB	0.422034	0	0	0	90.03
91.00	09100 EMERGENCY	0.569174	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.090813	0	0	0	92.00
200.00	Subtotal (see instructions)		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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141320 Component CCN: 14Z320	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/18/2015 9:22 am
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	88.02
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OP CLINIC	0	0	90.01
90.02	09002	SENIOR CARE	0	0	90.02
90.03	09003	SLEEP LAB	0	0	90.03
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/18/2015 9:22 am
	Title XIX	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0.356954	0	0	1,490,203	0	50.00
53.00 05300 ANESTHESIOLOGY	0.049560	0	0	231,299	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.139914	0	0	4,180,263	0	54.00
60.00 06000 LABORATORY	0.197420	0	0	2,193,996	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.619629	0	0	41,313	0	65.00
66.00 06600 PHYSICAL THERAPY	0.244966	0	0	984,781	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.122508	0	0	249,025	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	1.046871	0	0	6,148	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.291930	0	0	759,656	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.536796	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.383482	0	0	626,708	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	1.044367				0	88.00
88.01 08801 RURAL HEALTH CLINIC II	1.826473				0	88.01
88.02 08802 RURAL HEALTH CLINIC III	2.482676				0	88.02
90.00 09000 CLINIC	1.552197	0	0	19,398	0	90.00
90.01 09001 OP CLINIC	1.587060	0	0	13,641	0	90.01
90.02 09002 SENIOR CARE	0.965046	0	0	0	0	90.02
90.03 09003 SLEEP LAB	0.422034	0	0	37,266	0	90.03
91.00 09100 EMERGENCY	0.569174	0	0	1,780,862	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.090813	0	0	45,712	0	92.00
200.00 Subtotal (see instructions)		0	0	12,660,271	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	12,660,271	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/18/2015 9:22 am
	Title XIX	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	531,934		50.00
53.00 05300 ANESTHESIOLOGY	0	11,463		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	584,877		54.00
60.00 06000 LABORATORY	0	433,139		60.00
65.00 06500 RESPIRATORY THERAPY	0	25,599		65.00
66.00 06600 PHYSICAL THERAPY	0	241,238		66.00
69.00 06900 ELECTROCARDIOLOGY	0	30,508		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	6,436		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	221,766		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	240,331		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		88.01
88.02 08802 RURAL HEALTH CLINIC III	0	0		88.02
90.00 09000 CLINIC	0	30,110		90.00
90.01 09001 OP CLINIC	0	21,649		90.01
90.02 09002 SENIOR CARE	0	0		90.02
90.03 09003 SLEEP LAB	0	15,728		90.03
91.00 09100 EMERGENCY	0	1,013,620		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	49,863		92.00
200.00 Subtotal (see instructions)	0	3,458,261		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	3,458,261		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 5/18/2015 9:22 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,026	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,591	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)		1,430	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		808	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		2,627	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		911	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)		808	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		117.51	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		117.51	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,424,210	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)		308,699	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)		1,358,024	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,066,186	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)		2,066,186	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,298.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,183,088	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)		1,183,088	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/18/2015 9:22 am			
Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
Title XVIII			1.00	2.00	3.00	4.00	5.00	
Hospital								
Cost								
42.00	NURSERY (title V & XIX only)						42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT						43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
Cost Center Description								
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						1,252,913	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,436,001	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						1,049,325	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						1,049,325	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						161	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,298.67	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						209,086	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141320		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/18/2015 9:22 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	438,371	2,066,186	0.212164	209,086	44,361	90.00
91.00	Nursing School cost	0	2,066,186	0.000000	209,086	0	91.00
92.00	Allied health cost	0	2,066,186	0.000000	209,086	0	92.00
93.00	All other Medical Education	0	2,066,186	0.000000	209,086	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 5/18/2015 9:22 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,026	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,591	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)		1,430	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		808	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		2,627	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		135	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		117.51	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		117.51	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,424,210	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)		308,699	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)		1,358,024	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,066,186	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)		2,066,186	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,298.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		175,320	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)		175,320	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Prepared: 5/18/2015 9:22 am	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
Title XIX		1.00	2.00	3.00	4.00	5.00
Hospital						
Cost						
42.00	NURSERY (title V & XIX only)					42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT					43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					226,456 48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					401,776 49.00
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0 50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0 51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0 52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0 53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0 54.00
55.00	Target amount per discharge					0.00 55.00
56.00	Target amount (line 54 x line 55)					0 56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0 57.00
58.00	Bonus payment (see instructions)					0 58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00 59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00 60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0 61.00
62.00	Relief payment (see instructions)					0 62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0 63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0 64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0 66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0 67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0 68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0 69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					161 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,298.67 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					209,086 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141320		Period: From 01/01/2014 To 12/31/2014		Worksheet D-1 Date/Time Prepared: 5/18/2015 9:22 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	438,371	2,066,186	0.212164	209,086	44,361	90.00
91.00	Nursing School cost	0	2,066,186	0.000000	209,086	0	91.00
92.00	Allied health cost	0	2,066,186	0.000000	209,086	0	92.00
93.00	All other Medical Education	0	2,066,186	0.000000	209,086	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/18/2015 9:22 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		755,495		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.356954	662,646	236,534	50.00
53.00	05300 ANESTHESIOLOGY	0.049560	111,654	5,534	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.139914	282,106	39,471	54.00
60.00	06000 LABORATORY	0.197420	359,049	70,883	60.00
65.00	06500 RESPIRATORY THERAPY	0.619629	130,002	80,553	65.00
66.00	06600 PHYSICAL THERAPY	0.244966	256,091	62,734	66.00
69.00	06900 ELECTROCARDIOLOGY	0.122508	9,224	1,130	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.046871	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.291930	474,758	138,596	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.536796	756,296	405,977	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.383482	547,447	209,936	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000 CLINIC	1.552197	0	0	90.00
90.01	09001 OP CLINIC	1.587060	246	390	90.01
90.02	09002 SENIOR CARE	0.965046	0	0	90.02
90.03	09003 SLEEP LAB	0.422034	0	0	90.03
91.00	09100 EMERGENCY	0.569174	2,065	1,175	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.090813	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		3,591,584	1,252,913	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)		3,591,584		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3	
		Component CCN: 14Z320		Date/Time Prepared: 5/18/2015 9:22 am	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.356954	3,000	1,071	50.00
53.00	05300 ANESTHESIOLOGY	0.049560	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.139914	49,353	6,905	54.00
60.00	06000 LABORATORY	0.197420	46,479	9,176	60.00
65.00	06500 RESPIRATORY THERAPY	0.619629	67,000	41,515	65.00
66.00	06600 PHYSICAL THERAPY	0.244966	578,205	141,641	66.00
69.00	06900 ELECTROCARDIOLOGY	0.122508	941	115	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.046871	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.291930	56,162	16,395	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.536796	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.383482	187,465	71,889	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801 RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802 RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000 CLINIC	1.552197	0	0	90.00
90.01	09001 OP CLINIC	1.587060	0	0	90.01
90.02	09002 SENIOR CARE	0.965046	0	0	90.02
90.03	09003 SLEEP LAB	0.422034	0	0	90.03
91.00	09100 EMERGENCY	0.569174	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.090813	1,404	1,532	92.00
200.00	Total (sum of lines 50-94 and 96-98)		990,009	290,239	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)		990,009		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Prepared: 5/18/2015 9:22 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		161,734		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.356954	138,806	49,547	50.00
53.00	05300 ANESTHESIOLOGY	0.049560	24,030	1,191	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.139914	88,908	12,439	54.00
60.00	06000 LABORATORY	0.197420	89,543	17,678	60.00
65.00	06500 RESPIRATORY THERAPY	0.619629	19,090	11,829	65.00
66.00	06600 PHYSICAL THERAPY	0.244966	19,643	4,812	66.00
69.00	06900 ELECTROCARDIOLOGY	0.122508	5,083	623	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1.046871	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.291930	228,642	66,747	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.536796	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.383482	101,057	38,754	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	1.044367	0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	1.826473	0	0	88.01
88.02	08802 RURAL HEALTH CLINIC III	2.482676	0	0	88.02
90.00	09000 CLINIC	1.552197	0	0	90.00
90.01	09001 OP CLINIC	1.587060	0	0	90.01
90.02	09002 SENIOR CARE	0.965046	0	0	90.02
90.03	09003 SLEEP LAB	0.422034	0	0	90.03
91.00	09100 EMERGENCY	0.569174	36,394	20,715	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.090813	1,944	2,121	92.00
200.00	Total (sum of lines 50-94 and 96-98)		753,140	226,456	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)		753,140		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/18/2015 9:22 am
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			5,080,004 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 Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			5,080,004 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			5,130,804 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			40,477 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			2,632,462 26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			2,457,865 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,457,865 30.00
31.00	Primary payer payments			1,641 31.00
32.00	Subtotal (line 30 minus line 31)			2,456,224 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			646,652 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			491,456 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			2,947,680 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			2,947,680 40.00
40.01	Sequestration adjustment (see instructions)			58,954 40.01
41.00	Interim payments			3,637,275 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			-748,549 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141320

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

Worksheet E-1
Part I
Date/Time Prepared:
5/18/2015 9:22 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,059,173		2,955,991	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		50,713		633,818	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	12/15/2014	79,935	12/15/2014	26,607	3.01	
3.02		08/18/2014	245,454	08/18/2014	20,859	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)		325,389		47,466	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)		2,435,275		3,637,275	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		211,468		748,549	6.02	
7.00	Total Medicare program liability (see instructions)		2,223,807		2,888,726	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141320
Component CCN: 14Z320

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

Worksheet E-1
Part I
Date/Time Prepared:
5/18/2015 9:22 am

Title XVIII Swing Beds - SNF Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,425,434		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	12/15/2014	9,711		0	3.01
3.02		08/18/2014	25,031		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)		34,742		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,460,176		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		145,746		0	6.02
7.00	Total Medicare program liability (see instructions)		1,314,430		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 141320

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

Worksheet E-1
Part II
Date/Time Prepared:
5/18/2015 9:22 am

		Title XVIII	Hospital	Cost
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			480 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			911 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			57 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			1,430 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			70,395,641 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			794,163 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			1 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1 10.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			1 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141320

Period:

Worksheet E-2

Component CCN: 14Z320

From 01/01/2014

Date/Time Prepared:

To 12/31/2014

5/18/2015 9:22 am

		Title XVIII		Swing Beds - SNF	
		Part A	Part B	Cost	
		1.00	2.00		
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,059,818	0	1.00	
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00	
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	293,141	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	808	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)	1,352,959	0	8.00	
9.00	Primary payer payments (see instructions)	0	0	9.00	
10.00	Subtotal (line 8 minus line 9)	1,352,959	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)	1,352,959	0	12.00	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	11,704	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)	1,341,255	0	15.00	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00	
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50	
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55	
17.00	Allowable bad debts (see instructions)	0	0	17.00	
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01	
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00	
19.00	Total (see instructions)	1,341,255	0	19.00	
19.01	Sequestration adjustment (see instructions)	26,825	0	19.01	
20.00	Interim payments	1,460,176	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)	-145,746	0	22.00	
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part V Date/Time Prepared: 5/18/2015 9:22 am
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			2,436,001 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			2,436,001 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,460,361 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,460,361 19.00
20.00	Deductibles (exclude professional component)			255,103 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,205,258 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			2,205,258 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			84,122 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			63,933 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,269,191 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (see instructions)			2,269,191 30.00
30.01	Sequestration adjustment (see instructions)			45,384 30.01
31.00	Interim payments			2,435,275 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)			-211,468 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			303,357 34.00

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

Provider CCN: 141320

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

Worksheet G

Date/Time Prepared:
5/18/2015 9:22 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	6,727,193	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	23,360,417	0	0	0	4.00
5.00	Other receivable	676,149	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,719,007	0	0	0	6.00
7.00	Inventory	902,835	0	0	0	7.00
8.00	Prepaid expenses	459,151	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)	17,406,738	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	39,640,597	0	0	0	15.00
16.00	Accumulated depreciation	-24,323,725	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	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	15,316,872	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	18,218,790	0	0	0	33.00
34.00	Other assets	148,890	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	18,367,680	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	51,091,290	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,132,437	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	2,284,996	0	0	0	39.00
40.00	Notes and loans payable (short term)	642,325	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	1,491,055	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,550,813	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	3,001,392	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	3,001,392	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	8,552,205	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	42,539,085				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	42,539,085	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	51,091,290	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141320

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

Worksheet G-1

Date/Time Prepared:
5/18/2015 9:22 am

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		39,192,732		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,016,358			2.00
3.00	Total (sum of line 1 and line 2)		42,209,090		0	3.00
4.00	MISCELLANEOUS	329,995		0		4.00
5.00		0		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		329,995		0	10.00
11.00	Subtotal (line 3 plus line 10)		42,539,085		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		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)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		42,539,085		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	MISCELLANEOUS		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141320

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
5/18/2015 9:22 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,383,381		1,383,381	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	790,194		790,194	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,173,575		2,173,575	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,173,575		2,173,575	17.00
18.00	Ancillary services	8,019,540	52,420,077	60,439,617	18.00
19.00	Outpatient services	0	1,476,277	1,476,277	19.00
20.00	RURAL HEALTH CLINIC	0	5,907,484	5,907,484	20.00
20.01	RURAL HEALTH CLINIC II	0	301,302	301,302	20.01
20.02	RURAL HEALTH CLINIC III	0	97,382	97,382	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	1,295,281	14,541,113	15,836,394	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	11,488,396	74,743,635	86,232,031	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,368,746		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		36,368,746		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141320

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

Worksheet G-3

Date/Time Prepared:
5/18/2015 9:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	86,232,031	1.00
2.00	Less contractual allowances and discounts on patients' accounts	49,308,605	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,923,426	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,368,746	4.00
5.00	Net income from service to patients (line 3 minus line 4)	554,680	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	624,713	24.00
24.01	NON-OPERATING INCOME	1,836,965	24.01
25.00	Total other income (sum of lines 6-24)	2,461,678	25.00
26.00	Total (line 5 plus line 25)	3,016,358	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)	3,016,358	29.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141320 Component CCN: 143987	Period: From 01/01/2014 To 12/31/2014	Worksheet M-1 Date/Time Prepared: 5/18/2015 9:22 am
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	1,625,145	0	1,625,145	0	1,625,145	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	263,350	0	263,350	0	263,350	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	666,724	0	666,724	0	666,724	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	50	0	50	0	50	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,555,269	0	2,555,269	0	2,555,269	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	4,049	4,049	0	4,049	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	119,676	119,676	0	119,676	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	123,725	123,725	0	123,725	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,555,269	123,725	2,678,994	0	2,678,994	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	129,410	129,410	0	129,410	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	283,021	283,021	0	283,021	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	412,431	412,431	0	412,431	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	587,379	419,587	1,006,966	-15,539	991,427	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	587,379	419,587	1,006,966	-15,539	991,427	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,142,648	955,743	4,098,391	-15,539	4,082,852	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141320 Component CCN: 143987	Period: From 01/01/2014 To 12/31/2014	Worksheet M-1 Date/Time Prepared: 5/18/2015 9:22 am
		Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	1,625,145
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	263,350
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	666,724
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	50
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1 through 9)	0	2,555,269
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	4,049
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	119,676
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	123,725
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,678,994
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	129,410
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	283,021
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	412,431
FACILITY OVERHEAD			
29.00	Facility Costs	0	0
30.00	Administrative Costs	-133,194	858,233
31.00	Total Facility Overhead (sum of lines 29 and 30)	-133,194	858,233
32.00	Total facility costs (sum of lines 22, 28 and 31)	-133,194	3,949,658

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141320 Component CCN: 143989	Period: From 01/01/2014 To 12/31/2014	Worksheet M-1 Date/Time Prepared: 5/18/2015 9:22 am
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) II Reclassifications	Cost	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	22,253	0	22,253	0	22,253	1.00	
2.00	Physician Assistant	0	0	0	0	0	2.00	
3.00	Nurse Practitioner	109,165	0	109,165	0	109,165	3.00	
4.00	Visiting Nurse	0	0	0	0	0	4.00	
5.00	Other Nurse	49,766	0	49,766	0	49,766	5.00	
6.00	Clinical Psychologist	0	0	0	0	0	6.00	
7.00	Clinical Social Worker	0	0	0	0	0	7.00	
8.00	Laboratory Technician	4	0	4	0	4	8.00	
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00	
10.00	Subtotal (sum of lines 1 through 9)	181,188	0	181,188	0	181,188	10.00	
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00	
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00	
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00	
15.00	Medical Supplies	0	253	253	0	253	15.00	
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00	
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00	
18.00	Professional Liability Insurance	0	0	0	0	0	18.00	
19.00	Other Health Care Costs	0	0	0	0	0	19.00	
20.00	Allowable GME Costs	0	0	0	0	0	20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	253	253	0	253	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	181,188	253	181,441	0	181,441	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES								
23.00	Pharmacy	0	8,080	8,080	0	8,080	23.00	
24.00	Dental	0	0	0	0	0	24.00	
25.00	Optometry	0	0	0	0	0	25.00	
26.00	All other nonreimbursable costs	0	24,597	24,597	0	24,597	26.00	
27.00	Nonallowable GME costs	0	0	0	0	0	27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	32,677	32,677	0	32,677	28.00	
FACILITY OVERHEAD								
29.00	Facility Costs	0	0	0	0	0	29.00	
30.00	Administrative Costs	80,243	101,550	181,793	-32,149	149,644	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	80,243	101,550	181,793	-32,149	149,644	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	261,431	134,480	395,911	-32,149	363,762	32.00	

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141320 Component CCN: 143989	Period: From 01/01/2014 To 12/31/2014	Worksheet M-1 Date/Time Prepared: 5/18/2015 9:22 am
		Rural Health Clinic (RHC) II	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	22,253
2.00	Physician Assistant	0	0
3.00	Nurse Practitioner	0	109,165
4.00	Visiting Nurse	0	0
5.00	Other Nurse	0	49,766
6.00	Clinical Psychologist	0	0
7.00	Clinical Social Worker	0	0
8.00	Laboratory Technician	0	4
9.00	Other Facility Health Care Staff Costs	0	0
10.00	Subtotal (sum of lines 1 through 9)	0	181,188
11.00	Physician Services Under Agreement	0	0
12.00	Physician Supervision Under Agreement	0	0
13.00	Other Costs Under Agreement	0	0
14.00	Subtotal (sum of lines 11 through 13)	0	0
15.00	Medical Supplies	0	253
16.00	Transportation (Health Care Staff)	0	0
17.00	Depreciation-Medical Equipment	0	0
18.00	Professional Liability Insurance	0	0
19.00	Other Health Care Costs	0	0
20.00	Allowable GME Costs	0	0
21.00	Subtotal (sum of lines 15 through 20)	0	253
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	181,441
COSTS OTHER THAN RHC/FQHC SERVICES			
23.00	Pharmacy	0	8,080
24.00	Dental	0	0
25.00	Optometry	0	0
26.00	All other nonreimbursable costs	0	24,597
27.00	Nonallowable GME costs	0	0
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	32,677
FACILITY OVERHEAD			
29.00	Facility Costs	0	0
30.00	Administrative Costs	-2,690	146,954
31.00	Total Facility Overhead (sum of lines 29 and 30)	-2,690	146,954
32.00	Total facility costs (sum of lines 22, 28 and 31)	-2,690	361,072

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141320 Component CCN: 143431	Period: From 01/01/2014 To 12/31/2014	Worksheet M-1 Date/Time Prepared: 5/18/2015 9:22 am
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) III Reclassifications	Cost	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	10,385	0	10,385	0	10,385	1.00	
2.00	Physician Assistant	0	0	0	0	0	2.00	
3.00	Nurse Practitioner	56,549	0	56,549	0	56,549	3.00	
4.00	Visiting Nurse	0	0	0	0	0	4.00	
5.00	Other Nurse	23,466	0	23,466	0	23,466	5.00	
6.00	Clinical Psychologist	0	0	0	0	0	6.00	
7.00	Clinical Social Worker	0	0	0	0	0	7.00	
8.00	Laboratory Technician	2	0	2	0	2	8.00	
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00	
10.00	Subtotal (sum of lines 1 through 9)	90,402	0	90,402	0	90,402	10.00	
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00	
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00	
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00	
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00	
15.00	Medical Supplies	0	48	48	0	48	15.00	
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00	
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00	
18.00	Professional Liability Insurance	0	528	528	0	528	18.00	
19.00	Other Health Care Costs	0	0	0	0	0	19.00	
20.00	Allowable GME Costs	0	0	0	0	0	20.00	
21.00	Subtotal (sum of lines 15 through 20)	0	576	576	0	576	21.00	
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	90,402	576	90,978	0	90,978	22.00	
COSTS OTHER THAN RHC/FQHC SERVICES								
23.00	Pharmacy	0	1,520	1,520	0	1,520	23.00	
24.00	Dental	0	0	0	0	0	24.00	
25.00	Optometry	0	0	0	0	0	25.00	
26.00	All other nonreimbursable costs	0	8,896	8,896	0	8,896	26.00	
27.00	Nonallowable GME costs	0	0	0	0	0	27.00	
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	10,416	10,416	0	10,416	28.00	
FACILITY OVERHEAD								
29.00	Facility Costs	0	0	0	0	0	29.00	
30.00	Administrative Costs	25,638	39,514	65,152	-11,056	54,096	30.00	
31.00	Total Facility Overhead (sum of lines 29 and 30)	25,638	39,514	65,152	-11,056	54,096	31.00	
32.00	Total facility costs (sum of lines 22, 28 and 31)	116,040	50,506	166,546	-11,056	155,490	32.00	

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

Provider CCN: 141320

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

Worksheet M-1

Component CCN: 143431

Date/Time Prepared:
5/18/2015 9:22 am

Rural Health
Clinic (RHC) III

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	10,385	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	56,549	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	23,466	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	2	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	90,402	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	48	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	528	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	576	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	90,978	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	0	1,520	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	8,896	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	10,416	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	-1,110	52,986	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,110	52,986	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-1,110	154,380	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet M-2
		Component CCN: 143987		Date/Time Prepared: 5/18/2015 9:22 am
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	4.42	25,774	4,200	18,564	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	2.16	8,065	2,100	4,536	3.00
4.00	Subtotal (sum of lines 1 through 3)	6.58	33,839		23,100	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	6.58	33,839			8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES			
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)		2,678,994 10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		412,431 11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)		3,091,425 12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)		0.866589 13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)		858,233 14.00
15.00	Parent provider overhead allocated to facility (see instructions)		2,219,922 15.00
16.00	Total overhead (sum of lines 14 and 15)		3,078,155 16.00
17.00	Allowable GME overhead (see instructions)		0 17.00
18.00	Subtotal (see instructions)		3,078,155 18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)		2,667,495 19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		5,346,489 20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet M-2
		Component CCN: 143989		Date/Time Prepared: 5/18/2015 9:22 am
			Rural Health Clinic (RHC) II	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.01	0	4,200	42	1.00
2.00	Physician Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	1.02	1,710	2,100	2,142	3.00
4.00	Subtotal (sum of lines 1 through 3)	1.03	1,710		2,184	4.00
5.00	Visiting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.03	1,710		2,184	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)				181,441	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				32,677	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				214,118	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				0.847388	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)				146,954	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				189,248	15.00
16.00	Total overhead (sum of lines 14 and 15)				336,202	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtotal (see instructions)				336,202	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				284,894	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				466,335	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet M-2
		Component CCN: 143431		Date/Time Prepared: 5/18/2015 9:22 am
			Rural Health Clinic (RHC) III	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VI SITS AND PRODUCTI VI TY						
Posi tions						
1.00	Physi ci an	0.01	2	4,200	42	1.00
2.00	Physi ci an Assistant	0.00	0	2,100	0	2.00
3.00	Nurse Practitioner	0.48	529	2,100	1,008	3.00
4.00	Subtotal (sum of lines 1 through 3)	0.49	531		1,050	4.00
5.00	Visi ting Nurse	0.00	0		0	5.00
6.00	Clinical Psychologist	0.00	0		0	6.00
7.00	Clinical Social Worker	0.00	0		0	7.00
7.01	Medical Nutri tion Therapist (FQHC only)	0.00	0		0	7.01
7.02	Diabetes Sel f Management Training (FQHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.49	531		1,050	8.00
9.00	Physi ci an Servi ces Under Agreements		0		0	9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLI CABLE TO RHC/FQHC SERVICES						
10.00	Total costs of heal th care services (from Wkst. M-1, col. 7, line 22)				90,978	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				10,416	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				101,394	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				0.897272	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)				52,986	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				87,388	15.00
16.00	Total overhead (sum of lines 14 and 15)				140,374	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtotal (see instructions)				140,374	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				125,954	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				216,932	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet M-3
		Component CCN: 143987		Date/Time Prepared: 5/18/2015 9:22 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		5,346,489	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		40,081	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		5,306,408	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		33,839	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		33,839	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		156.81	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)	163.87	163.87	8.00
9.00	Rate for Program covered visits (see instructions)	156.81	156.81	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	7,572	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,187,365	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) *		1,187,365	16.00
16.01	Total program charges (see instructions)(from contractor's records)		884,858	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,204	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		8,325	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.)		847,751	16.04
16.05	Total program cost (see instructions)		856,076	16.05
17.00	Primary payer amounts		194	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		119,351	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		151,860	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		855,882	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		16,076	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		871,958	22.00
23.00	Allowable bad debts (see instructions)		58,012	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		44,089	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
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		916,047	26.00
26.01	Sequestration adjustment (see instructions)		18,321	26.01
27.00	Interim payments		788,412	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)		109,314	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet M-3
		Component CCN: 143989		Date/Time Prepared: 5/18/2015 9:22 am
		Title XVIII	Rural Health Clinic (RHC) II	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		466,335	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		7,329	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		459,006	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,184	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,184	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		210.17	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)	187.22	187.22	8.00
9.00	Rate for Program covered visits (see instructions)	210.17	210.17	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	329	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	69,146	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) *		69,146	16.00
16.01	Total program charges (see instructions)(from contractor's records)		35,157	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		505	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		993	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.)		49,943	16.04
16.05	Total program cost (see instructions)		50,936	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,724	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,786	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		50,936	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,018	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		53,954	22.00
23.00	Allowable bad debts (see instructions)		1,047	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		796	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
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		54,750	26.00
26.01	Sequestration adjustment (see instructions)		1,095	26.01
27.00	Interim payments		36,322	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)		17,333	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141320	Period: From 01/01/2014 To 12/31/2014	Worksheet M-3
		Component CCN: 143431		Date/Time Prepared: 5/18/2015 9:22 am
		Title XVIII	Rural Health Clinic (RHC) III	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		216,932	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		1,050	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		215,882	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		1,050	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,050	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		205.60	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)	194.56	194.56	8.00
9.00	Rate for Program covered visits (see instructions)	205.60	205.60	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	86	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	17,682	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) *		17,682	16.00
16.01	Total program charges (see instructions)(from contractor's records)		9,472	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		760	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,419	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.)		11,958	16.04
16.05	Total program cost (see instructions)		13,377	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		1,315	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		1,479	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		13,377	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		686	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		14,063	22.00
23.00	Allowable bad debts (see instructions)		364	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		277	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
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		14,340	26.00
26.01	Sequestration adjustment (see instructions)		287	26.01
27.00	Interim payments		11,649	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)		2,404	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141320 Component CCN: 143987	Period: From 01/01/2014 To 12/31/2014	Worksheet M-4 Date/Time Prepared: 5/18/2015 9:22 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2,555,269	2,555,269	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	5,589	13,062	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	5,589	13,062	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	2,678,994	2,678,994	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	3,078,155	3,078,155	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002086	0.004876	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,421	15,009	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	12,010	28,071	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	822	78	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	14.61	359.88	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	386	29	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	5,639	10,437	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		40,081	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		16,076	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141320 Component CCN: 143989	Period: From 01/01/2014 To 12/31/2014	Worksheet M-4 Date/Time Prepared: 5/18/2015 9:22 am
		Title XVIII	Rural Health Clinic (RHC) II	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	181,188	181,188	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,218	1,351	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,218	1,351	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	181,441	181,441	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	336,202	336,202	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006713	0.007446	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,257	2,503	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,475	3,854	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	17	85	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	204.41	45.34	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	7	35	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,431	1,587	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		7,329	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		3,018	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141320
Component CCN: 143431

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

Worksheet M-4
Date/Time Prepared:
5/18/2015 9:22 am

Title XVIII

Rural Health
Clinic (RHC) III

Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	90,402	90,402	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	413	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	413	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	90,978	90,978	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	140,374	140,374	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.004540	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	637	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	1,050	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	26	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	40.38	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	17	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	686	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		1,050	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		686	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141320 Component CCN: 143987	Period: From 01/01/2014 To 12/31/2014	Worksheet M-5 Date/Time Prepared: 5/18/2015 9:22 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		779,595	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		12/18/2014	8,817	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)		8,817	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		788,412	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		109,314	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		897,726	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141320 Component CCN: 143989	Period: From 01/01/2014 To 12/31/2014	Worksheet M-5 Date/Time Prepared: 5/18/2015 9:22 am
		Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		39,425	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50		12/18/2014	3,103	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)		-3,103	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		36,322	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		17,333	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		53,655	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141320 Component CCN: 143431	Period: From 01/01/2014 To 12/31/2014	Worksheet M-5 Date/Time Prepared: 5/18/2015 9:22 am
		Rural Health Clinic (RHC) III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		11,649	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		11,649	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		2,404	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		14,053	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00