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: 140019	Period: From 09/01/2014 To 08/31/2015	Worksheet S Parts I-III Date/Time Prepared: 1/28/2016 2:14 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 1/28/2016 Time: 2:14 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SHELBY MEMORIAL HOSPITAL (140019) for the cost reporting period beginning 09/01/2014 and ending 08/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	104,851	-6,257	255,486	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	2,164	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		85,710		0	10.00
200.00	Total	0	107,015	79,453	255,486	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 1/28/2016 2:12 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 200 SOUTH CEDAR	PO Box:			1.00
2.00	City: SHELBYBILLE	State: IL	Zip Code: 62565-1899	County: SHELBY	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SHELBY MEMORIAL HOSPITAL	140019	99914	1	07/01/1966	N	P	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	SHELBY MEMORIAL HOSPITAL SWING BED	14U019	99914		04/13/1993	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SHELBY MEMORIAL HOSPITAL HHA	147622	99914		08/03/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	SHELBY MEMORIAL HOSPITAL RHC	143446	99914		06/05/1998	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	09/01/2014	08/31/2015	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.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	356	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 1/28/2016 2:12 pm

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		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.	09/01/2014	08/31/2015	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the 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)	Y	Y	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.	N			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, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

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

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

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

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

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

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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	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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		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
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		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/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	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 is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	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, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	140,088	0	0	118.01

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		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	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:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00
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, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 140019	Period: From 09/01/2014 To 08/31/2015	Worksheet S-2 Part I Date/Time Prepared: 1/28/2016 2:12 pm

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
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)						0.25	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)					09/01/2014	08/31/2015	170.00
							1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)						N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 1/28/2016 2:12 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	10/27/2015	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: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 1/28/2016 2:12 pm

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

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	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.	PATTY	RACHELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544	PRACHELL@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 1/28/2016 2:12 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	10/27/2015			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.		DIRECTOR		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: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 1/28/2016 2:12 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	30	10,950	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		30	10,950	0.00	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)		30	10,950	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		30				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: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 1/28/2016 2:12 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	806	356	1,559			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	335	0	335			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	20			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,141	356	1,914			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)	1,141	356	1,914	0.00	131.28	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	3,857	0	3,857	0.00	7.12	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,188	1,931	7,080	0.00	9.68	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	148.08	27.00
28.00	Observation Bed Days		75	537			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			22			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: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 1/28/2016 2:12 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	231	166	557	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		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	231	166	557	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 1/28/2016 2:12 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	6,924,586	0	6,924,586	307,981.61	22.48	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		545,920	0	545,920	7,104.61	76.84	5.00
6.00	Non-physician-Part B		235,753	0	235,753	13,028.43	18.10	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		679,423	19,926	699,349	22,091.74	31.66	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		279,838	0	279,838	5,543.00	50.48	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		301,824	0	301,824	3,368.00	89.62	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		1,576,989	0	1,576,989			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		143,591	0	143,591			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		70,995	0	70,995			23.00
24.00	Wage-related costs (RHC/FQHC)		77,069	0	77,069			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	60,385	0	60,385	2,142.00	28.19	26.00
27.00	Administrative & General	5.00	938,396	0	938,396	44,295.80	21.18	27.00
28.00	Administrative & General under contract (see inst.)		176,691	0	176,691	791.70	223.18	28.00
29.00	Maintenance & Repairs	6.00	259,804	0	259,804	12,284.27	21.15	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	47,667	0	47,667	4,399.77	10.83	31.00
32.00	Housekeeping	9.00	168,424	-19,926	148,498	14,238.76	10.43	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	205,077	-157,328	47,749	4,303.71	11.09	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	157,328	157,328	13,216.81	11.90	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	434,203	0	434,203	14,570.84	29.80	38.00
39.00	Central Services and Supply	14.00	120,394	0	120,394	7,111.95	16.93	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 1/28/2016 2:12 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	222,715	0	222,715	15,102.92	14.75	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-3 Part III Date/Time Prepared: 1/28/2016 2:12 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		6,319,604	0	6,319,604	288,640.27	21.89	1.00
2.00	Excluded area salaries (see instructions)		679,423	19,926	699,349	22,091.74	31.66	2.00
3.00	Subtotal salaries (line 1 minus line 2)		5,640,181	-19,926	5,620,255	266,548.53	21.09	3.00
4.00	Subtotal other wages & related costs (see inst.)		581,662	0	581,662	8,911.00	65.27	4.00
5.00	Subtotal wage-related costs (see inst.)		1,576,989	0	1,576,989	0.00	28.06	5.00
6.00	Total (sum of lines 3 thru 5)		7,798,832	-19,926	7,778,906	275,459.53	28.24	6.00
7.00	Total overhead cost (see instructions)		2,633,756	-19,926	2,613,830	132,458.53	19.73	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 1/28/2016 2:12 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	202,890	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	23,973	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,015,955	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	5,271	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)	18,766	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	98,428	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	491,376	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	11,984	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	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	1,868,643	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-3 Part V Date/Time Prepared: 1/28/2016 2:12 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	279,838	0	1.00
2.00	Hospital	279,838	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 140019 | Component CCN: 147622 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-4 | Date/Time Prepared: 1/28/2016 2:12 pm

Home Health Agency I | PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	302	0	17	319	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	127.00	9.00	30.00	166.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		1.30	0.00	1.30	5.00
6.00	Direct Nursing Service		4.03	0.00	4.03	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.37	0.00	0.37	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.20	0.00	0.20	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.01	0.00	0.01	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.21	0.00	0.21	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914			20.00

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,111	422	45	10	1,588	21.00
22.00	Skilled Nursing Visit Charges	174,427	66,254	7,065	1,570	249,316	22.00
23.00	Physical Therapy Visits	646	43	8	6	703	23.00
24.00	Physical Therapy Visit Charges	109,269	7,353	1,368	1,026	119,016	24.00
25.00	Occupational Therapy Visits	286	23	0	0	309	25.00
26.00	Occupational Therapy Visit Charges	57,772	4,646	0	0	62,418	26.00
27.00	Speech Pathology Visits	4	0	0	0	4	27.00
28.00	Speech Pathology Visit Charges	760	0	0	0	760	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	177	13	0	0	190	31.00
32.00	Home Health Aide Visit Charges	14,514	1,066	0	0	15,580	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,224	501	53	16	2,794	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	356,742	79,319	8,433	2,596	447,090	35.00
36.00	Total Number of Episodes (standard/non outlier)	138		19	2	159	36.00
37.00	Total Number of Outlier Episodes		11		0	11	37.00
38.00	Total Non-Routine Medical Supply Charges	3,802	1,030	121	2	4,955	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-7 | Date/Time Prepared: 1/28/2016 2:12 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	04/13/1993	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	23	23	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	0	0	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	7	7	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	7	7	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	4	4	30.00
31.00		HD2	0	7	7	31.00
32.00		HD1	0	12	12	32.00
33.00		HC2	0	10	10	33.00
34.00		HC1	0	35	35	34.00
35.00		HB2	0	3	3	35.00
36.00		HB1	0	60	60	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	4	4	46.00
47.00		CD2	0	7	7	47.00
48.00		CD1	0	23	23	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	13	13	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	20	20	52.00
53.00		CA2	0	1	1	53.00
54.00		CA1	0	88	88	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-7 | Date/Time Prepared: 1/28/2016 2:12 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	9	9	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	2	2	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	335	335	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	0			207.00

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

Provider CCN: 140019 Component CCN: 143446 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-8 | Date/Time Prepared: 1/28/2016 2:12 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	200 SOUTH CEDAR STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	SHELBYVILLE	IL	62565	2.00

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

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

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

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

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		SHELBY				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	19:00	08:00	19:00	08:00	19:00	11.00

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

Provider CCN: 140019
Component CCN: 143446

Period:
From 09/01/2014
To 08/31/2015

Worksheet S-8

Date/Time Prepared:
1/28/2016 2:12 pm

Rural Health Clinic (RHC) I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet S-10 | Date/Time Prepared: 1/28/2016 2:12 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.460958	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	633,578	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	4,577,583	6.00
7.00	Medicaid cost (line 1 times line 6)	2,110,074	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	1,476,496	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,476,496	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	132,438	128,312	260,750	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	61,048	59,146	120,194	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	61,048	59,146	120,194	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,096,049	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	63,356	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,032,693	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	476,028	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	596,222	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,072,718	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet A | Date/Time Prepared: 1/28/2016 2:12 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		1,364,479	1,364,479	-176,710	1,187,769	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	721,344	721,344	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	60,385	1,754,692	1,815,077	120,786	1,935,863	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	938,396	2,018,662	2,957,058	-299,160	2,657,898	5.00
6.00	00600	MAINTENANCE & REPAIRS	259,804	103,852	363,656	-60	363,596	6.00
7.00	00700	OPERATION OF PLANT	0	301,684	301,684	-57,482	244,202	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	47,667	20,672	68,339	0	68,339	8.00
9.00	00900	HOUSEKEEPING	168,424	12,740	181,164	-19,926	161,238	9.00
10.00	01000	DIETARY	205,077	242,051	447,128	-343,022	104,106	10.00
11.00	01100	CAFETERIA	0	0	0	343,022	343,022	11.00
13.00	01300	NURSING ADMINISTRATION	434,203	54,604	488,807	0	488,807	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	120,394	23,185	143,579	-525	143,054	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	222,715	17,060	239,775	0	239,775	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	79,293	79,293	0	79,293	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	722,800	289,455	1,012,255	-2,280	1,009,975	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	121,876	114,885	236,761	-74,235	162,526	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	440,158	353,512	793,670	0	793,670	54.00
60.00	06000	LABORATORY	387,839	662,312	1,050,151	0	1,050,151	60.00
65.00	06500	RESPIRATORY THERAPY	177,971	55,048	233,019	943	233,962	65.00
66.00	06600	PHYSICAL THERAPY	403,615	15,367	418,982	-525	418,457	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	33,524	33,524	0	33,524	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	987,441	987,441	2,928	990,369	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	48,424	1,675	50,099	0	50,099	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	781,673	37,187	818,860	49,497	868,357	88.00
90.00	09000	CLINIC	144,904	19,814	164,718	-3,690	161,028	90.00
91.00	09100	EMERGENCY	447,415	839,830	1,287,245	-1,060	1,286,185	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	111,423	105,700	217,123	-5,217	211,906	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	372,395	48,822	421,217	-4,109	417,108	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		363,118	363,118	-363,118	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,617,558	9,920,664	16,538,222	-112,599	16,425,623	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	307,028	5,306	312,334	92,568	404,902	192.00
194.00	07950	FARM EXPENSES	0	0	0	20,031	20,031	194.00
200.00		TOTAL (SUM OF LINES 118-199)	6,924,586	9,925,970	16,850,556	0	16,850,556	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet A | Date/Time Prepared: 1/28/2016 2:12 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-363,118	824,651		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	721,344		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-441,384	1,494,479		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-478,237	2,179,661		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	363,596		6.00
7.00	00700	OPERATION OF PLANT	0	244,202		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	68,339		8.00
9.00	00900	HOUSEKEEPING	0	161,238		9.00
10.00	01000	DIETARY	0	104,106		10.00
11.00	01100	CAFETERIA	-71,505	271,517		11.00
13.00	01300	NURSING ADMINISTRATION	0	488,807		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	143,054		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,667	235,108		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-79,293	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-48,140	961,835		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	162,526		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	793,670		54.00
60.00	06000	LABORATORY	0	1,050,151		60.00
65.00	06500	RESPIRATORY THERAPY	-10,707	223,255		65.00
66.00	06600	PHYSICAL THERAPY	0	418,457		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-2,136	31,388		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	990,369		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	-17,908	32,191		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	868,357		88.00
90.00	09000	CLINIC	-3,913	157,115		90.00
91.00	09100	EMERGENCY	-526,167	760,018		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-10	211,896		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	-26,018	391,090		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,073,203	14,352,420		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	404,902		192.00
194.00	07950	FARM EXPENSES	0	20,031		194.00
200.00		TOTAL (SUM OF LINES 118-199)	-2,073,203	14,777,353		200.00

RECLASSIFICATIONS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet A-6 | Date/Time Prepared: 1/28/2016 2:12 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - MEDICAL CENTER RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	19,926	0	1.00
	0		19,926	0	
	B - FIRE INSURANCE RECLASS				
1.00	OTHER CAP REL COSTS	3.00	0	24,680	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,393	2.00
	0		0	26,073	
	C - TELEPHONE EXPENSE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,470	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	0		0	8,470	
	D - WORKER'S COMPENSATION INS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	96,813	1.00
	0		0	96,813	
	E - RENTAL EXPENSE RECLASS				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	118,857	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
	0		0	118,857	
	F - MEDICAL CENTER UTILITLES RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	57,482	1.00
	0		0	57,482	
	G - PHYSICIAN BUILDING DEPR RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	13,767	1.00
2.00		0.00	0	0	2.00
	0		0	13,767	
	H - DEPRECIATION EXPENSE RECLASS				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	567,208	1.00
	0		0	567,208	
	I - PROPERTY INSURANCE RECLASS				
1.00	OTHER CAP REL COSTS	3.00	0	42,437	1.00
	0		0	42,437	
	J - CAFETERIA EXPENSE RECLASS				
1.00	CAFETERIA	11.00	157,328	185,694	1.00
	0		157,328	185,694	
	K - REAL ESTATE TAX RECLASS				
1.00	OTHER CAP REL COSTS	3.00	0	9,309	1.00
2.00	FARM EXPENSES	194.00	0	20,031	2.00
	0		0	29,340	
	L - ONCOLOGY PHARMACY COSTS RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,690	1.00
	0		0	3,690	
	M - INTEREST EXPENSE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	363,118	1.00
	0		0	363,118	
	O - PENSION AUDIT COSTS RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	23,973	1.00
	0		0	23,973	
	P - RHC PHYSICIAN RECRUITMENT				
1.00	RURAL HEALTH CLINIC	88.00	0	54,142	1.00
	0		0	54,142	
	Q - RHC PHYSICIAN READING EKGS				
1.00	RESPIRATORY THERAPY	65.00	943	0	1.00
	TOTALS		943	0	
500.00	Grand Total: Increases		178,197	1,591,064	500.00

RECLASSIFICATIONS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet A-6 | Date/Time Prepared: 1/28/2016 2:12 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - MEDICAL CENTER RECLASS					
1.00	HOUSEKEEPING	9.00	19,926	0	0	1.00
	0		19,926	0		
	B - FIRE INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	26,073	5	1.00
2.00		0.00	0	0	0	2.00
	0		0	26,073		
	C - TELEPHONE EXPENSE RECLASS					
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	525	0	1.00
2.00	PHYSICAL THERAPY	66.00	0	525	0	2.00
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	762	0	3.00
4.00	RURAL HEALTH CLINIC	88.00	0	3,702	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	10	0	5.00
6.00	HOME HEALTH AGENCY	101.00	0	2,946	0	6.00
	0		0	8,470		
	D - WORKER'S COMPENSATION INS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	96,813	0	1.00
	0		0	96,813		
	E - RENTAL EXPENSE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	34,852	10	1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	60	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	2,280	0	3.00
4.00	OPERATING ROOM	50.00	0	74,235	0	4.00
5.00	EMERGENCY	91.00	0	1,060	0	5.00
6.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	5,207	0	6.00
7.00	HOME HEALTH AGENCY	101.00	0	1,163	0	7.00
	0		0	118,857		
	F - MEDICAL CENTER UTILITLES RECLASS					
1.00	OPERATION OF PLANT	7.00	0	57,482	0	1.00
	0		0	57,482		
	G - PHYSICIAN BUILDING DEPR RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	12,318	9	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,449	9	2.00
	0		0	13,767		
	H - DEPRECIATION EXPENSE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	567,208	9	1.00
	0		0	567,208		
	I - PROPERTY INSURANCE RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	42,437	5	1.00
	0		0	42,437		
	J - CAFETERIA EXPENSE RECLASS					
1.00	DIETARY	10.00	157,328	185,694	0	1.00
	0		157,328	185,694		
	K - REAL ESTATE TAX RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	29,340	0	1.00
2.00		0.00	0	0	0	2.00
	0		0	29,340		
	L - ONCOLOGY PHARMACY COSTS RECLASS					
1.00	CLINIC	90.00	0	3,690	0	1.00
	0		0	3,690		
	M - INTEREST EXPENSE RECLASS					
1.00	INTEREST EXPENSE	113.00	0	363,118	11	1.00
	0		0	363,118		
	O - PENSION AUDIT COSTS RECLASS					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	23,973	0	1.00
	0		0	23,973		
	P - RHC PHYSICIAN RECRUITMENT					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	54,142	0	1.00
	0		0	54,142		
	Q - RHC PHYSICIAN READING EKGS					
1.00	RURAL HEALTH CLINIC	88.00	943	0	0	1.00
	TOTALS		943	0		
500.00	Grand Total: Decreases		178,197	1,591,064		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 1/28/2016 2:12 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	991,651	0	0	0	0	1.00
2.00	Land Improvements	255,908	25,080	0	25,080	0	2.00
3.00	Buildings and Fixtures	15,211,091	3,240	0	3,240	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,820,220	13,689	0	13,689	0	5.00
6.00	Movable Equipment	10,316,726	150,896	0	150,896	48,080	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,595,596	192,905	0	192,905	48,080	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,595,596	192,905	0	192,905	48,080	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	991,651	0	1.00
2.00	Land Improvements	280,988	0	2.00
3.00	Buildings and Fixtures	15,214,331	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,833,909	0	5.00
6.00	Movable Equipment	10,419,542	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	31,740,421	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	31,740,421	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 1/28/2016 2:12 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	1,361,736	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,361,736	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	2,743	1,364,479		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	2,743	1,364,479		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 1/28/2016 2:12 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	16,486,971	0	16,486,971	0.519431	34,863	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,253,451	0	15,253,451	0.480569	32,254	2.00
3.00	Total (sum of lines 1-2)	31,740,422	0	31,740,422	1.000000	67,117	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	4,835	0	39,698	782,210	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,474	0	36,728	565,759	118,857	2.00
3.00	Total (sum of lines 1-2)	9,309	0	76,426	1,347,969	118,857	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	34,863	4,835	2,743	824,651	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	32,254	4,474	0	721,344	2.00
3.00	Total (sum of lines 1-2)	0	67,117	9,309	2,743	1,545,995	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet A-8 | Date/Time Prepared: 1/28/2016 2:12 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-363,118	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-3,590	ADMINISTRATIVE & GENERAL	5.00	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	-588,927			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	-71,505	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-2,136	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-4,667	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist	A	-79,293	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	SELF INSURANCE EXPENSE	A	-441,194	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01	ADVERTISING	A	-47,732	ADMINISTRATIVE & GENERAL	5.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet A-8 | Date/Time Prepared: 1/28/2016 2:12 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	MISCELLANEOUS INCOME	B	-4,387	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	NURSING SERVICES SOLD	B	-26,018	HOME HEALTH AGENCY	101.00	0	33.03
33.04			0		0.00	0	33.04
33.05	PROMOTIONAL ITEMS	A	-5,746	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	SWITCHBOARD SALARY EXPENSE	A	-706	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SWITCHBOARD BENEFIT EXPENSE	A	-190	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	PATIENT TELEPHONES	A	-3,705	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	LOBBYING DUES	A	-5,730	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	FRA TAX	A	-385,701	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11			0		0.00	0	33.11
33.12			0		0.00	0	33.12
33.13			0		0.00	0	33.13
33.14	DME MISCELLANEOUS INCOME	B	-10	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.14
33.15	WELLNESS FOR LIFE REVENUE	B	-17,908	CARDIAC REHABILITATION	76.97	0	33.15
33.16	FOUNDATION AND FUNDRAISING EXPENSES	A	-16,121	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17	MISC EXPENSE	A	-4,819	ADMINISTRATIVE & GENERAL	5.00	0	33.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,073,203				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: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 1/28/2016 2:12 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	48,140	48,140	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	10,707	10,707	0	0	0	2.00
3.00	90.00	CLINIC	3,913	3,913	0	0	0	3.00
4.00	91.00	EMERGENCY	784,920	483,096	301,824	159,800	3,368	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			847,680	545,856	301,824		3,368	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	2.00
3.00	90.00	CLINIC	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	258,753	12,938	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			258,753	12,938	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	30.00	ADULTS & PEDIATRICS	0	0	0	48,140		1.00
2.00	65.00	RESPIRATORY THERAPY	0	0	0	10,707		2.00
3.00	90.00	CLINIC	0	0	0	3,913		3.00
4.00	91.00	EMERGENCY	0	258,753	43,071	526,167		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	258,753	43,071	588,927		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet B Part I Date/Time Prepared: 1/28/2016 2:12 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	824,651	824,651				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	721,344		721,344			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,494,479	9,337	8,167	1,511,983		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,179,661	98,783	86,408	206,569	2,571,421	5.00
6.00	00600	MAINTENANCE & REPAIRS	363,596	19,858	17,371	57,233	458,058	6.00
7.00	00700	OPERATION OF PLANT	244,202	19,105	16,712	0	280,019	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68,339	16,691	14,600	10,501	110,131	8.00
9.00	00900	HOUSEKEEPING	161,238	7,930	6,937	32,713	208,818	9.00
10.00	01000	DIETARY	104,106	25,263	22,098	11,097	162,564	10.00
11.00	01100	CAFETERIA	271,517	8,860	7,750	34,080	322,207	11.00
13.00	01300	NURSING ADMINISTRATION	488,807	7,620	6,665	95,652	598,744	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	143,054	43,327	37,900	26,522	250,803	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	235,108	19,471	17,032	49,063	320,674	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	961,835	119,284	104,339	159,228	1,344,686	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	162,526	68,990	60,347	26,848	318,711	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	793,670	58,468	51,143	96,964	1,000,245	54.00
60.00	06000	LABORATORY	1,050,151	23,115	20,219	85,438	1,178,923	60.00
65.00	06500	RESPIRATORY THERAPY	223,255	16,303	14,261	39,206	293,025	65.00
66.00	06600	PHYSICAL THERAPY	418,457	42,696	37,347	88,914	587,414	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	31,388	0	0	0	31,388	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	990,369	8,750	7,654	0	1,006,773	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	32,191	15,816	13,835	10,667	72,509	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	868,357	53,340	46,658	172,197	1,140,552	88.00
90.00	09000	CLINIC	157,115	85,702	74,966	31,921	349,704	90.00
91.00	09100	EMERGENCY	760,018	22,195	19,415	98,562	900,190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	211,896	19,759	17,284	24,546	273,485	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	391,090	13,988	12,236	82,036	499,350	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,352,420	824,651	721,344	1,439,957	14,280,394	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	404,902	0	0	72,026	476,928	192.00
194.00	07950	FARM EXPENSES	20,031	0	0	0	20,031	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	14,777,353	824,651	721,344	1,511,983	14,777,353	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet B Part I | Date/Time Prepared: 1/28/2016 2:12 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,571,421					5.00
6.00	00600	MAINTENANCE & REPAIRS	96,499	554,557				6.00
7.00	00700	OPERATION OF PLANT	58,992	15,208	354,219			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	23,201	13,286	8,726	155,344		8.00
9.00	00900	HOUSEKEEPING	43,992	6,312	4,146	0	263,268	9.00
10.00	01000	DIETARY	34,247	20,110	13,207	0	10,186	10.00
11.00	01100	CAFETERIA	67,879	7,053	4,632	0	3,573	11.00
13.00	01300	NURSING ADMINISTRATION	126,137	6,066	3,984	0	3,072	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	52,837	34,489	22,651	294	17,470	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	67,556	15,499	10,179	0	7,851	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	283,282	94,950	62,358	72,454	48,094	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	67,143	54,916	36,066	647	27,817	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	210,722	46,541	30,566	28,360	23,574	54.00
60.00	06000	LABORATORY	248,364	18,399	12,084	61	9,320	60.00
65.00	06500	RESPIRATORY THERAPY	61,732	12,977	8,523	118	6,573	65.00
66.00	06600	PHYSICAL THERAPY	123,751	33,986	22,321	12,739	17,215	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,613	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	212,097	6,965	4,574	0	3,528	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	15,275	12,590	8,268	0	6,377	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	240,280	42,459	27,885	209	21,507	88.00
90.00	09000	CLINIC	73,672	68,220	44,804	255	34,555	90.00
91.00	09100	EMERGENCY	189,643	17,668	11,603	40,207	8,949	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	57,615	15,728	10,329	0	7,967	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	105,198	11,135	7,313	0	5,640	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,466,727	554,557	354,219	155,344	263,268	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	100,474	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	4,220	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	2,571,421	554,557	354,219	155,344	263,268	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet B Part I | Date/Time Prepared: 1/28/2016 2:12 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	240,314					10.00
11.00	01100	CAFETERIA	0	405,344				11.00
13.00	01300	NURSING ADMINISTRATION	0	27,716	765,719			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,528	19,528	411,600		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	28,728	0	1,776	452,263	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	240,314	71,951	373,654	0	160,271	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	8,910	46,267	0	8,861	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	31,438	0	10,977	121,991	54.00
60.00	06000	LABORATORY	0	37,801	0	306,960	44,369	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,748	81,777	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	27,598	0	0	17,754	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	49,896	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	20,018	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	3,949	20,506	0	6,670	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	38,273	0	5,078	70,179	88.00
90.00	09000	CLINIC	0	13,827	71,801	5,310	0	90.00
91.00	09100	EMERGENCY	0	29,306	152,186	0	22,168	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	14,549	0	11,585	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	28,167	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	240,314	391,489	765,719	411,600	452,263	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	13,855	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	240,314	405,344	765,719	411,600	452,263	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet B Part I | Date/Time Prepared: 1/28/2016 2:12 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,752,014	0	2,752,014		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	569,338	0	569,338		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,504,414	0	1,504,414		54.00
60.00	06000	LABORATORY	0	1,856,281	0	1,856,281		60.00
65.00	06500	RESPIRATORY THERAPY	0	480,473	0	480,473		65.00
66.00	06600	PHYSICAL THERAPY	0	842,778	0	842,778		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	87,897	0	87,897		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,253,955	0	1,253,955		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	146,144	0	146,144		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,586,422	0	1,586,422		88.00
90.00	09000	CLINIC	0	662,148	0	662,148		90.00
91.00	09100	EMERGENCY	0	1,371,920	0	1,371,920		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	391,258	0	391,258		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY	0	656,803	0	656,803		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	14,161,845	0	14,161,845		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	591,257	0	591,257		192.00
194.00	07950	FARM EXPENSES	0	24,251	0	24,251		194.00
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)	0	14,777,353	0	14,777,353		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet B Part II | Date/Time Prepared: 1/28/2016 2:12 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,337	8,167	17,504	17,504	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	98,783	86,408	185,191	2,393	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	19,858	17,371	37,229	663	6.00
7.00	00700	OPERATION OF PLANT	0	19,105	16,712	35,817	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	16,691	14,600	31,291	122	8.00
9.00	00900	HOUSEKEEPING	0	7,930	6,937	14,867	379	9.00
10.00	01000	DIETARY	0	25,263	22,098	47,361	128	10.00
11.00	01100	CAFETERIA	0	8,860	7,750	16,610	394	11.00
13.00	01300	NURSING ADMINISTRATION	0	7,620	6,665	14,285	1,107	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	43,327	37,900	81,227	307	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	19,471	17,032	36,503	568	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	119,284	104,339	223,623	1,843	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	68,990	60,347	129,337	311	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	58,468	51,143	109,611	1,122	54.00
60.00	06000	LABORATORY	0	23,115	20,219	43,334	989	60.00
65.00	06500	RESPIRATORY THERAPY	0	16,303	14,261	30,564	454	65.00
66.00	06600	PHYSICAL THERAPY	0	42,696	37,347	80,043	1,029	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,750	7,654	16,404	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	15,816	13,835	29,651	123	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	53,340	46,658	99,998	1,993	88.00
90.00	09000	CLINIC	0	85,702	74,966	160,668	370	90.00
91.00	09100	EMERGENCY	0	22,195	19,415	41,610	1,141	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	19,759	17,284	37,043	284	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	13,988	12,236	26,224	950	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	824,651	721,344	1,545,995	16,670	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	834	192.00
194.00	07950	FARM EXPENSES	20,031	0	0	20,031	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	20,031	824,651	721,344	1,566,026	17,504	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet B Part II | Date/Time Prepared: 1/28/2016 2:12 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	187,584					5.00
6.00	00600	MAINTENANCE & REPAIRS	7,039	44,931				6.00
7.00	00700	OPERATION OF PLANT	4,303	1,232	41,352			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,692	1,076	1,019	35,200		8.00
9.00	00900	HOUSEKEEPING	3,209	511	484	0	19,450	9.00
10.00	01000	DIETARY	2,498	1,629	1,542	0	753	10.00
11.00	01100	CAFETERIA	4,952	571	541	0	264	11.00
13.00	01300	NURSING ADMINISTRATION	9,201	491	465	0	227	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,854	2,794	2,644	67	1,291	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,928	1,256	1,188	0	580	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,672	7,697	7,280	16,416	3,550	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,898	4,449	4,210	147	2,055	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,372	3,771	3,568	6,426	1,742	54.00
60.00	06000	LABORATORY	18,118	1,491	1,411	14	689	60.00
65.00	06500	RESPIRATORY THERAPY	4,503	1,051	995	27	486	65.00
66.00	06600	PHYSICAL THERAPY	9,027	2,754	2,606	2,887	1,272	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	482	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,472	564	534	0	261	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,114	1,020	965	0	471	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	17,528	3,440	3,255	47	1,589	88.00
90.00	09000	CLINIC	5,374	5,527	5,230	58	2,553	90.00
91.00	09100	EMERGENCY	13,834	1,431	1,355	9,111	661	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	4,203	1,274	1,206	0	589	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	7,674	902	854	0	417	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	179,947	44,931	41,352	35,200	19,450	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,329	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	308	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	187,584	44,931	41,352	35,200	19,450	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet B Part II | Date/Time Prepared: 1/28/2016 2:12 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	53,911					10.00
11.00	01100	CAFETERIA	0	23,332				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,595	27,371			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	779	698	93,661		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,654	0	404	47,081	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	53,911	4,141	13,356	0	16,685	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	513	1,654	0	922	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,810	0	2,498	12,699	54.00
60.00	06000	LABORATORY	0	2,176	0	69,851	4,619	60.00
65.00	06500	RESPIRATORY THERAPY	0	906	2,923	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,589	0	0	1,848	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	11,354	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	4,555	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	227	733	0	694	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,203	0	1,155	7,306	88.00
90.00	09000	CLINIC	0	796	2,567	1,208	0	90.00
91.00	09100	EMERGENCY	0	1,687	5,440	0	2,308	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	837	0	2,636	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	0	1,621	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	53,911	22,534	27,371	93,661	47,081	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	798	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	53,911	23,332	27,371	93,661	47,081	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet B Part II | Date/Time Prepared: 1/28/2016 2:12 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		369,174	0	369,174		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		148,496	0	148,496		50.00
53.00	05300	ANESTHESIOLOGY		0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		158,619	0	158,619		54.00
60.00	06000	LABORATORY		142,692	0	142,692		60.00
65.00	06500	RESPIRATORY THERAPY		41,909	0	41,909		65.00
66.00	06600	PHYSICAL THERAPY		103,055	0	103,055		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		11,836	0	11,836		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		37,790	0	37,790		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS		0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION		34,998	0	34,998		76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		138,514	0	138,514		88.00
90.00	09000	CLINIC		184,351	0	184,351		90.00
91.00	09100	EMERGENCY		78,578	0	78,578		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED		48,072	0	48,072		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD		0	0	0		97.00
101.00	10100	HOME HEALTH AGENCY		38,642	0	38,642		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,536,726	0	1,536,726		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		8,961	0	8,961		192.00
194.00	07950	FARM EXPENSES		20,339	0	20,339		194.00
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)	0	1,566,026	0	1,566,026		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet B-1 | Date/Time Prepared: 1/28/2016 2:12 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	74,457					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		74,457				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	843	843	6,863,495			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,919	8,919	937,690	-2,571,421	12,205,932	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,793	1,793	259,804	0	458,058	6.00
7.00	00700	OPERATION OF PLANT	1,725	1,725	0	0	280,019	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,507	1,507	47,667	0	110,131	8.00
9.00	00900	HOUSEKEEPING	716	716	148,498	0	208,818	9.00
10.00	01000	DIETARY	2,281	2,281	50,375	0	162,564	10.00
11.00	01100	CAFETERIA	800	800	154,702	0	322,207	11.00
13.00	01300	NURSING ADMINISTRATION	688	688	434,203	0	598,744	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,912	3,912	120,394	0	250,803	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,758	1,758	222,715	0	320,674	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,770	10,770	722,800	0	1,344,686	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,229	6,229	121,876	0	318,711	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279	5,279	440,158	0	1,000,245	54.00
60.00	06000	LABORATORY	2,087	2,087	387,839	0	1,178,923	60.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,472	177,971	0	293,025	65.00
66.00	06600	PHYSICAL THERAPY	3,855	3,855	403,615	0	587,414	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	31,388	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790	790	0	0	1,006,773	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,428	1,428	48,424	0	72,509	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,816	4,816	781,673	0	1,140,552	88.00
90.00	09000	CLINIC	7,738	7,738	144,904	0	349,704	90.00
91.00	09100	EMERGENCY	2,004	2,004	447,415	0	900,190	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,784	1,784	111,423	0	273,485	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	1,263	1,263	372,395	0	499,350	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,457	74,457	6,536,541	-2,571,421	11,708,973	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	326,954	0	476,928	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	20,031	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	824,651	721,344	1,511,983		2,571,421	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.075534	9.688062	0.220293		0.210670	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			17,504		187,584	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002550		0.015368	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet B-1 | Date/Time Prepared: 1/28/2016 2:12 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	62,902					6.00
7.00	00700	OPERATION OF PLANT	1,725	61,177				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,507	1,507	71,323			8.00
9.00	00900	HOUSEKEEPING	716	716	0	58,954		9.00
10.00	01000	DIETARY	2,281	2,281	0	2,281	8,968	10.00
11.00	01100	CAFETERIA	800	800	0	800	0	11.00
13.00	01300	NURSING ADMINISTRATION	688	688	0	688	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,912	3,912	135	3,912	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,758	1,758	0	1,758	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,770	10,770	33,266	10,770	8,968	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,229	6,229	297	6,229	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,279	5,279	13,021	5,279	0	54.00
60.00	06000	LABORATORY	2,087	2,087	28	2,087	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,472	1,472	54	1,472	0	65.00
66.00	06600	PHYSICAL THERAPY	3,855	3,855	5,849	3,855	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	790	790	0	790	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1,428	1,428	0	1,428	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,816	4,816	96	4,816	0	88.00
90.00	09000	CLINIC	7,738	7,738	117	7,738	0	90.00
91.00	09100	EMERGENCY	2,004	2,004	18,460	2,004	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,784	1,784	0	1,784	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	1,263	1,263	0	1,263	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,902	61,177	71,323	58,954	8,968	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	554,557	354,219	155,344	263,268	240,314	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.816206	5.790068	2.178035	4.465651	26.796833	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	44,931	41,352	35,200	19,450	53,911	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.714302	0.675940	0.493529	0.329918	6.011485	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet B-1 | Date/Time Prepared: 1/28/2016 2:12 pm

		Cost Center Description	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	14.00	16.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	213,101					11.00
13.00	01300	NURSING ADMINISTRATION	14,571	77,520				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,112	1,977	628,525			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	15,103	0	2,712	14,036		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,828	37,828	0	4,974	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,684	4,684	0	275	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	16,528	0	16,762	3,786	0	54.00
60.00	06000	LABORATORY	19,873	0	468,738	1,377	0	60.00
65.00	06500	RESPIRATORY THERAPY	8,279	8,279	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	14,509	0	0	551	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	76,192	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	30,568	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	2,076	2,076	0	207	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	20,121	0	7,754	2,178	0	88.00
90.00	09000	CLINIC	7,269	7,269	8,108	0	0	90.00
91.00	09100	EMERGENCY	15,407	15,407	0	688	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	7,649	0	17,691	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	14,808	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	205,817	77,520	628,525	14,036	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,284	0	0	0	0	192.00
194.00	07950	FARM EXPENSES	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	405,344	765,719	411,600	452,263	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1.902122	9.877696	0.654867	32.221644	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,332	27,371	93,661	47,081	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.109488	0.353083	0.149017	3.354303	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet C Part I Date/Time Prepared: 1/28/2016 2:12 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,752,014		2,752,014	0	2,752,014	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	569,338		569,338	0	569,338	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,504,414		1,504,414	0	1,504,414	54.00
60.00	06000	LABORATORY	1,856,281		1,856,281	0	1,856,281	60.00
65.00	06500	RESPIRATORY THERAPY	480,473	0	480,473	0	480,473	65.00
66.00	06600	PHYSICAL THERAPY	842,778	0	842,778	0	842,778	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	87,897		87,897	0	87,897	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,253,955		1,253,955	0	1,253,955	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0		0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	146,144		146,144	0	146,144	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,586,422		1,586,422	0	1,586,422	88.00
90.00	09000	CLINIC	662,148		662,148	0	662,148	90.00
91.00	09100	EMERGENCY	1,371,920		1,371,920	43,071	1,414,991	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	705,070		705,070		705,070	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	391,258		391,258	0	391,258	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
101.00	10100	HOME HEALTH AGENCY	656,803		656,803		656,803	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	14,866,915	0	14,866,915	43,071	14,909,986	200.00
201.00		Less Observation Beds	705,070		705,070		705,070	201.00
202.00		Total (see instructions)	14,161,845	0	14,161,845	43,071	14,204,916	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet C Part I Date/Time Prepared: 1/28/2016 2:12 pm

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,580,524		2,580,524			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,694	1,002,534	1,016,228	0.560246	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	446,054	8,790,653	9,236,707	0.162873	0.000000	54.00
60.00	06000	LABORATORY	869,652	6,841,481	7,711,133	0.240727	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	212,520	1,441,243	1,653,763	0.290533	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	137,711	1,271,189	1,408,900	0.598182	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	282,205	180,299	462,504	0.190046	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	364,175	782,813	1,146,988	1.093259	0.000000	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	96,273	96,273	1.518016	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	696,477	696,477			88.00
90.00	09000	CLINIC	3,731	502,153	505,884	1.308893	0.000000	90.00
91.00	09100	EMERGENCY	107,637	2,313,023	2,420,660	0.566755	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	153,843	665,249	819,092	0.860795	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	334,596	334,596	1.169345	0.000000	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0.000000	0.000000	97.00
101.00	10100	HOME HEALTH AGENCY	0	632,923	632,923			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,171,746	25,550,906	30,722,652			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,171,746	25,550,906	30,722,652			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet C Part I Date/Time Prepared: 1/28/2016 2:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.560246
53.00	05300	ANESTHESIOLOGY	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162873
60.00	06000	LABORATORY	0.240727
65.00	06500	RESPIRATORY THERAPY	0.290533
66.00	06600	PHYSICAL THERAPY	0.598182
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.190046
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	1.093259
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000
76.97	07697	CARDIAC REHABILITATION	1.518016
		OUTPATIENT SERVICE COST CENTERS	
88.00	08800	RURAL HEALTH CLINIC	
90.00	09000	CLINIC	1.308893
91.00	09100	EMERGENCY	0.584548
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.860795
		OTHER REIMBURSABLE COST CENTERS	
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.169345
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000
101.00	10100	HOME HEALTH AGENCY	
		SPECIAL PURPOSE COST CENTERS	
113.00	11300	INTEREST EXPENSE	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet D Part I Date/Time Prepared: 1/28/2016 2:12 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	369,174	0	369,174	2,096	176.13	30.00
200.00	Total (lines 30-199)	369,174		369,174	2,096		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	806	141,961				30.00
200.00	Total (lines 30-199)	806	141,961				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet D Part II Date/Time Prepared: 1/28/2016 2:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	148,496	1,016,228	0.146125	13,694	2,001	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	158,619	9,236,707	0.017173	402,210	6,907	54.00
60.00	06000	LABORATORY	142,692	7,711,133	0.018505	693,275	12,829	60.00
65.00	06500	RESPIRATORY THERAPY	41,909	1,653,763	0.025342	160,364	4,064	65.00
66.00	06600	PHYSICAL THERAPY	103,055	1,408,900	0.073146	71,358	5,220	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,836	462,504	0.025591	199,181	5,097	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,790	1,146,988	0.032947	234,151	7,715	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	34,998	96,273	0.363529	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	138,514	696,477	0.198878	0	0	88.00
90.00	09000	CLINIC	184,351	505,884	0.364414	0	0	90.00
91.00	09100	EMERGENCY	78,578	2,420,660	0.032461	78,588	2,551	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	94,583	819,092	0.115473	134,249	15,502	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	48,072	334,596	0.143672	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0	0	97.00
200.00		Total (lines 50-199)	1,223,493	27,509,205		1,987,070	61,886	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet D Part III Date/Time Prepared: 1/28/2016 2:12 pm

Title XVIII | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,096	0.00	806	0		30.00
200.00		Total (lines 30-199)	2,096		806	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet D Part IV | Date/Time Prepared: 1/28/2016 2:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet D Part IV | Date/Time Prepared: 1/28/2016 2:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,016,228	0.000000	0.000000	13,694	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,236,707	0.000000	0.000000	402,210	54.00
60.00	06000	LABORATORY	0	7,711,133	0.000000	0.000000	693,275	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,653,763	0.000000	0.000000	160,364	65.00
66.00	06600	PHYSICAL THERAPY	0	1,408,900	0.000000	0.000000	71,358	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	462,504	0.000000	0.000000	199,181	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,146,988	0.000000	0.000000	234,151	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.000000	0.000000	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	96,273	0.000000	0.000000	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	696,477	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	505,884	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	2,420,660	0.000000	0.000000	78,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	819,092	0.000000	0.000000	134,249	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	334,596	0.000000	0.000000	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000	0.000000	0	97.00
200.00		Total (lines 50-199)	0	27,509,205			1,987,070	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet D Part IV Date/Time Prepared: 1/28/2016 2:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	630,074	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,857,951	0		54.00
60.00	06000	LABORATORY	0	1,367,799	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	692,724	0		65.00
66.00	06600	PHYSICAL THERAPY	0	145,692	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	104,629	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	781,616	0		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	57,545	0		76.97
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	22,921	0		90.00
91.00	09100	EMERGENCY	0	724,085	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	362,787	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0		97.00
200.00		Total (lines 50-199)	0	8,747,823	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet D Part V Date/Time Prepared: 1/28/2016 2:12 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.560246	630,074	0	0	352,996	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162873	3,857,951	0	0	628,356	54.00
60.00	06000	LABORATORY	0.240727	1,367,799	738	0	329,266	60.00
65.00	06500	RESPIRATORY THERAPY	0.290533	692,724	0	0	201,259	65.00
66.00	06600	PHYSICAL THERAPY	0.598182	145,692	0	0	87,150	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.190046	104,629	0	0	19,884	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.093259	781,616	0	394	854,509	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.518016	57,545	0	0	87,354	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.308893	22,921	0	0	30,001	90.00
91.00	09100	EMERGENCY	0.566755	724,085	0	0	410,379	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.860795	362,787	0	0	312,285	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.169345	0	0	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	0	0	97.00
200.00		Subtotal (see instructions)		8,747,823	738	394	3,313,439	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		8,747,823	738	394	3,313,439	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet D Part V Date/Time Prepared: 1/28/2016 2:12 pm

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	178	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	431		73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
200.00		Subtotal (see instructions)	178	431		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	178	431		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet D-1 | Date/Time Prepared: 1/28/2016 2:12 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,451	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,096	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)	1,559	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	335	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	7	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)	13	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	806	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)	335	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,752,014	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,752,014	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)	2,752,014	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)	1,312.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,058,262	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)	1,058,262	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet D-1 | Date/Time Prepared: 1/28/2016 2:12 pm

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	784,688	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,842,950	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)	141,961	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	61,886	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	203,847	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,639,103	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/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID 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)	537	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,312.98	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	705,070	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet D-1 | Date/Time Prepared: 1/28/2016 2:12 pm

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	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	369,174	2,752,014	0.134147	705,070	94,583	90.00
91.00	Nursing School cost	0	2,752,014	0.000000	705,070	0	91.00
92.00	Allied health cost	0	2,752,014	0.000000	705,070	0	92.00
93.00	All other Medical Education	0	2,752,014	0.000000	705,070	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet D-3 | Date/Time Prepared: 1/28/2016 2:12 pm

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,360,705		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.560246	13,694	7,672	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162873	402,210	65,509	54.00
60.00	06000	LABORATORY	0.240727	693,275	166,890	60.00
65.00	06500	RESPIRATORY THERAPY	0.290533	160,364	46,591	65.00
66.00	06600	PHYSICAL THERAPY	0.598182	71,358	42,685	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.190046	199,181	37,854	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.093259	234,151	255,988	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.518016	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.308893	0	0	90.00
91.00	09100	EMERGENCY	0.584548	78,588	45,938	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.860795	134,249	115,561	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.169345	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		1,987,070	784,688	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,987,070		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140019 | Component CCN: 14U019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet D-3 | Date/Time Prepared: 1/28/2016 2:12 pm

Title XVIII | Swing Beds - SNF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.560246	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162873	43,844	7,141	54.00
60.00	06000	LABORATORY	0.240727	93,039	22,397	60.00
65.00	06500	RESPIRATORY THERAPY	0.290533	51,749	15,035	65.00
66.00	06600	PHYSICAL THERAPY	0.598182	66,353	39,691	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.190046	71,728	13,632	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.093259	82,639	90,346	73.00
76.00	03950	OTHER ANCILLARY SERVICE COST CENTERS	0.000000	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	1.518016	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.308893	0	0	90.00
91.00	09100	EMERGENCY	0.566755	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.860795	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1.169345	0	0	96.00
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97.00
200.00		Total (sum of lines 50-94 and 96-98)		409,352	188,242	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		409,352		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet E Part A Date/Time Prepared: 1/28/2016 2:12 pm

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		89,757			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		987,331			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0			1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0			1.04
2.00	Outlier payments for discharges. (see instructions)		0			2.00
2.01	Outlier reconciliation amount		0			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0			2.02
3.00	Managed Care Simulated Payments		0			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		27.56			4.00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00			5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00			6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00			7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00			7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00			8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00			8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00			9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00			10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00			11.00
12.00	Current year allowable FTE (see instructions)		0.00			12.00
13.00	Total allowable FTE count for the prior year.		0.00			13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00			14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00			15.00
16.00	Adjustment for residents in initial years of the program		0.00			16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00			17.00
18.00	Adjusted rolling average FTE count		0.00			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000			21.00
22.00	IME payment adjustment (see instructions)		0			22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00			23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00			24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00			25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000			26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000			27.00
28.00	IME add-on adjustment amount (see instructions)		0			28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0			28.01
29.00	Total IME payment (sum of lines 22 and 28)		0			29.00

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0			29.01
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.61			30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.52			31.00
32.00	Sum of lines 30 and 31		25.13			32.00
33.00	Allowable disproportionate share percentage (see instructions)		9.95			33.00
34.00	Disproportionate share adjustment (see instructions)		26,793			34.00

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143		7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000012051		0.000007209	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		109,014		55,132	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		8,960		50,601	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		59,561			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		1,163,442			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		1,324,552			48.00
49.00	Total payment for inpatient operating costs (see instructions)		1,324,552			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		84,786			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		1,409,338			59.00
60.00	Primary payer payments		0			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		1,409,338			61.00
62.00	Deductibles billed to program beneficiaries		189,100			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet E Part A Date/Time Prepared: 1/28/2016 2:12 pm

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			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		0			63.00
64.00	Allowable bad debts (see instructions)		18,244			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		11,859			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		18,244			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		1,232,097			67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0			68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0			69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			70.00
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0			70.91
70.92	Bundled Model 1 discount amount (see instructions)		0			70.92
70.93	HVBP payment adjustment amount (see instructions)		-6,534			70.93
70.94	HRR adjustment amount (see instructions)		-4,587			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2014	23,572			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2015	289,290			70.97
70.98	Low Volume Payment-3		0			70.98
70.99	HAC adjustment amount (see instructions)		0			70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		1,533,838			71.00
71.01	Sequestration adjustment (see instructions)		30,677			71.01
72.00	Interim payments		1,398,310			72.00
73.00	Tentative settlement (for contractor use only)		0			73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		104,851			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0			75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0			90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

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		Prior to 10/1		On/After 10/1	
		1.00	1.01	2.00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)	0		0	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0		0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0		0	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0		0	104.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 1/28/2016 2:12 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	89,757	0	89,757	0	89,757	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	987,331	0	0	987,331	987,331	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	0	0	0	0	0	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0995	0.0995	0.0995	0.0995		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	26,793	0	2,233	24,560	26,793	11.00
11.01	Uncompensated care payments	36.00	59,561	0	8,960	50,601	59,561	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	1,163,442	0	100,950	1,062,492	1,163,442	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	1,324,552	0	108,321	1,216,231	1,324,552	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	1,324,552	0	108,321	1,216,231	1,324,552	15.00
16.00	Payment for inpatient program capital	50.00	84,786	0	7,066	77,720	84,786	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 1/28/2016 2:12 pm

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	115,387	1,293,951	1,409,338	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	84,786	0	7,066	77,720	84,786	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	0	0	0	0	0	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	84,786	0	7,066	77,720	84,786	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.204286	0.223571		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			23,572		23,572	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				289,290	289,290	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140019	Period: From 09/01/2014 To 08/31/2015	Worksheet E Part B Date/Time Prepared: 1/28/2016 2:12 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	609	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,313,439	2.00
3.00	PPS payments	1,847,013	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)	609	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,132	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	1,132	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	1,132	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	523	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)	609	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)	1,847,013	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	426,428	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] (see instructions)	1,421,194	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)	1,421,194	30.00
31.00	Primary payer payments	37	31.00
32.00	Subtotal (line 30 minus line 31)	1,421,157	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)	64,367	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	41,839	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	64,367	36.00
37.00	Subtotal (see instructions)	1,462,996	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)	1,462,996	40.00
40.01	Sequestration adjustment (see instructions)	29,260	40.01
41.00	Interim payments	1,439,993	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-6,257	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: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 1/28/2016 2:12 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,549,589		1,452,386	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	08/27/2015	104,326		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	03/31/2015	255,605	03/31/2015	12,393	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)		-151,279		-12,393	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)		1,398,310		1,439,993	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		104,851		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		6,257	6.02
7.00	Total Medicare program liability (see instructions)		1,503,161		1,433,736	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: 140019 | Component CCN: 14U019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 1/28/2016 2:12 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		77,554		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		77,554		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		2,164		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		79,718		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: 140019	Period: From 09/01/2014 To 08/31/2015	Worksheet E-1 Part II Date/Time Prepared: 1/28/2016 2:12 pm
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD 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	557	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	806	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,559	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	30,722,652	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	260,750	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	260,700	8.00
9.00	Sequestration adjustment amount (see instructions)	5,214	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	255,486	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & 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)	255,486	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 140019 | Component CCN: 14U019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet E-2 | Date/Time Prepared: 1/28/2016 2:12 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	95,195	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 Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	335	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)	95,195	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	95,195	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)	95,195	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	16,058	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)	79,137	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)	2,905	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	2,208	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,905	0	18.00
19.00	Total (see instructions)	81,345	0	19.00
19.01	Sequestration adjustment (see instructions)	1,627	0	19.01
20.00	Interim payments	77,554	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)	2,164	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet G | Date/Time Prepared: 1/28/2016 2:12 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	214,157	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5,240,491	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,945,883	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	426,878	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	115,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	3,050,643	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	991,652	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	-393,589	0	0	0	14.00
15.00	Buildings	15,495,319	0	0	0	15.00
16.00	Accumulated depreciation	-9,800,688	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	4,833,910	0	0	0	19.00
20.00	Accumulated depreciation	-3,792,278	0	0	0	20.00
21.00	Automobiles and trucks	10,419,541	0	0	0	21.00
22.00	Accumulated depreciation	-8,775,728	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)	8,978,139	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	18,837,559	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	309,254	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	19,146,813	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	31,175,595	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	441,401	0	0	0	37.00
38.00	Salaries, wages, and fees payable	590,110	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,800,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	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)	8,831,511	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	210,000	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	210,000	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	9,041,511	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	22,134,084				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)	22,134,084	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	31,175,595	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet G-1 | Date/Time Prepared: 1/28/2016 2:12 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		26,499,675		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-4,365,591				2.00
3.00	Total (sum of line 1 and line 2)		22,134,084		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		22,134,084		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		22,134,084		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 1/28/2016 2:12 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,119,747		2,119,747	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	486,432		486,432	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)	2,606,179		2,606,179	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)	2,606,179		2,606,179	17.00
18.00	Ancillary services	2,352,766	20,860,107	23,212,873	18.00
19.00	Outpatient services	267,116	3,508,969	3,776,085	19.00
20.00	RURAL HEALTH CLINIC	0	696,477	696,477	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		632,923	632,923	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	DME	0	334,596	334,596	27.00
27.01	PRO FEES	1,422	400,495	401,917	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,227,483	26,433,567	31,661,050	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,850,556		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		16,850,556		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet G-3 | Date/Time Prepared: 1/28/2016 2:12 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	31,661,050	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,225,999	2.00
3.00	Net patient revenues (line 1 minus line 2)	12,435,051	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,850,556	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,415,505	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	49,930	6.00
7.00	Income from investments	-366,114	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	71,505	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	2,136	17.00
18.00	Revenue from sale of medical records and abstracts	4,667	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	83,738	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	FARM INCOME	147,280	24.01
24.02	GAIN ON SALE OF EQUIPMENT	4,109	24.02
24.03	LIFELINE INCOME	0	24.03
24.04	NURSING SERVICES	26,018	24.04
24.05	PROFESSIONAL FEES	750	24.05
24.06	MISELLANEOUS INCOME	4,397	24.06
24.07	EHR INCENTIVE PAYMENT	0	24.07
24.08	WELLNESS FOR LIFE	21,498	24.08
24.09	OTHER (SPECIFY)	0	24.09
25.00	Total other income (sum of lines 6-24)	49,914	25.00
26.00	Total (line 5 plus line 25)	-4,365,591	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-4,365,591	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140019 | HHA CCN: 147622 | Period: From 09/01/2014 To 08/31/2015 | Worksheet H | Date/Time Prepared: 1/28/2016 2:12 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	144,470	0	26,577	0	22,245	193,292	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	170,874	0	0	0	0	170,874	6.00
7.00	Physical Therapy	32,631	0	0	0	0	32,631	7.00
8.00	Occupational Therapy	16,833	0	0	0	0	16,833	8.00
9.00	Speech Pathology	1,017	0	0	0	0	1,017	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	6,570	0	0	0	0	6,570	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	372,395	0	26,577	0	22,245	421,217	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	-4,109	189,183	-26,018	163,165			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	170,874	0	170,874			6.00
7.00	Physical Therapy	0	32,631	0	32,631			7.00
8.00	Occupational Therapy	0	16,833	0	16,833			8.00
9.00	Speech Pathology	0	1,017	0	1,017			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	6,570	0	6,570			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	-4,109	417,108	-26,018	391,090			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 140019 | HHA CCN: 147622 | Period: From 09/01/2014 To 08/31/2015 | Worksheet H-1 Part I | Date/Time Prepared: 1/28/2016 2:12 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	163,165	0	0	0	0	163,165	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	170,874	0	0	0	0	170,874	6.00
7.00	Physical Therapy	32,631	0	0	0	0	32,631	7.00
8.00	Occupational Therapy	16,833	0	0	0	0	16,833	8.00
9.00	Speech Pathology	1,017	0	0	0	0	1,017	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	6,570	0	0	0	0	6,570	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	391,090	0	0	0	0	391,090	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	163,165		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	122,324	293,198	6.00
7.00	Physical Therapy	23,360	55,991	7.00
8.00	Occupational Therapy	12,050	28,883	8.00
9.00	Speech Pathology	728	1,745	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	4,703	11,273	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		391,090	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140019 HHA CCN: 147622

Period: From 09/01/2014 To 08/31/2015

Worksheet H-1 Part II Date/Time Prepared: 1/28/2016 2:12 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-163,165	227,925	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	170,874	6.00
7.00	Physical Therapy	0	0	0	0	0	32,631	7.00
8.00	Occupational Therapy	0	0	0	0	0	16,833	8.00
9.00	Speech Pathology	0	0	0	0	0	1,017	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	6,570	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-163,165	227,925	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		163,165	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.715871	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140019 HHA CCN: 147622 | Period: From 09/01/2014 To 08/31/2015 | Worksheet H-2 Part I Date/Time Prepared: 1/28/2016 2:12 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	13,988	12,236	31,826	58,050	12,229	1.00
2.00	Skilled Nursing Care	293,198	0	0	37,643	330,841	69,698	2.00
3.00	Physical Therapy	55,991	0	0	7,188	63,179	13,310	3.00
4.00	Occupational Therapy	28,883	0	0	3,708	32,591	6,866	4.00
5.00	Speech Pathology	1,745	0	0	224	1,969	415	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	11,273	0	0	1,447	12,720	2,680	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	391,090	13,988	12,236	82,036	499,350	105,198	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	11,135	7,313	0	5,640	0	28,167	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	11,135	7,313	0	5,640	0	28,167	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140019 HHA CCN: 147622 | Period: From 09/01/2014 To 08/31/2015 | Worksheet H-2 Part I Date/Time Prepared: 1/28/2016 2:12 pm

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	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	16.00	19.00	24.00	25.00	
1.00	Administrative and General	0	0	0	0	122,534	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	400,539	0	2.00
3.00	Physical Therapy	0	0	0	0	76,489	0	3.00
4.00	Occupational Therapy	0	0	0	0	39,457	0	4.00
5.00	Speech Pathology	0	0	0	0	2,384	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	15,400	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	656,803	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs				
		26.00	27.00	28.00				
1.00	Administrative and General	122,534						1.00
2.00	Skilled Nursing Care	400,539	91,863	492,402				2.00
3.00	Physical Therapy	76,489	17,543	94,032				3.00
4.00	Occupational Therapy	39,457	9,049	48,506				4.00
5.00	Speech Pathology	2,384	547	2,931				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	15,400	3,532	18,932				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
20.00	Total (sum of lines 1-19) (2)	656,803	122,534	656,803				20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.229349					21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140019 HHA CCN: 147622

Period: From 09/01/2014 To 08/31/2015

Worksheet H-2 Part II Date/Time Prepared: 1/28/2016 2:12 pm

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	1,263	1,263	144,470	0	58,050	1,263	1.00
2.00	Skilled Nursing Care	0	0	170,874	0	330,841	0	2.00
3.00	Physical Therapy	0	0	32,631	0	63,179	0	3.00
4.00	Occupational Therapy	0	0	16,833	0	32,591	0	4.00
5.00	Speech Pathology	0	0	1,017	0	1,969	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	6,570	0	12,720	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,263	1,263	372,395		499,350	1,263	20.00
21.00	Total cost to be allocated	13,988	12,236	82,036		105,198	11,135	21.00
22.00	Unit cost multiplier	11.075218	9.688044	0.220293		0.210670	8.816310	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	1,263	0	1,263	0	14,808	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,263	0	1,263	0	14,808	0	20.00
21.00	Total cost to be allocated	7,313	0	5,640	0	28,167	0	21.00
22.00	Unit cost multiplier	5.790182	0.000000	4.465558	0.000000	1.902147	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140019 HHA CCN: 147622

Period: From 09/01/2014 To 08/31/2015

Worksheet H-2 Part II Date/Time Prepared: 1/28/2016 2:12 pm

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	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)			
		14.00	16.00	19.00			
1.00	Administrative and General	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0			2.00
3.00	Physical Therapy	0	0	0			3.00
4.00	Occupational Therapy	0	0	0			4.00
5.00	Speech Pathology	0	0	0			5.00
6.00	Medical Social Services	0	0	0			6.00
7.00	Home Health Aide	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0			8.00
9.00	Drugs	0	0	0			9.00
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0			15.00
16.00	Day Care Program	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0			17.00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
20.00	Total (sum of lines 1-19)	0	0	0			20.00
21.00	Total cost to be allocated	0	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140019 | HHA CCN: 147622 | Period: From 09/01/2014 To 08/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 1/28/2016 2:12 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	492,402		492,402	2,055	239.61	1.00
2.00	Physical Therapy	3.00	94,032	0	94,032	1,028	91.47	2.00
3.00	Occupational Therapy	4.00	48,506	0	48,506	463	104.76	3.00
4.00	Speech Pathology	5.00	2,931	0	2,931	14	209.36	4.00
5.00	Medical Social Services	6.00	0		0	0	0.00	5.00
6.00	Home Health Aide	7.00	18,932		18,932	297	63.74	6.00
7.00	Total (sum of lines 1-6)		656,803	0	656,803	3,857		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	1,588			8.00
9.00	Physical Therapy		99914	0	703			9.00
10.00	Occupational Therapy		99914	0	309			10.00
11.00	Speech Pathology		99914	0	4			11.00
12.00	Medical Social Services		99914	0	0			12.00
13.00	Home Health Aide		99914	0	190			13.00
14.00	Total (sum of lines 8-13)			0	2,794			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	942	942	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Cost of Services Part B Not Subject to Deductibles & Coinsurance	Cost of Services Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,588		0	380,501		1.00
2.00	Physical Therapy	0	703		0	64,303		2.00
3.00	Occupational Therapy	0	309		0	32,371		3.00
4.00	Speech Pathology	0	4		0	837		4.00
5.00	Medical Social Services	0	0		0	0		5.00
6.00	Home Health Aide	0	190		0	12,111		6.00
7.00	Total (sum of lines 1-6)	0	2,794		0	490,123		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 140019 HHA CCN: 147622 | Period: From 09/01/2014 To 08/31/2015 | Worksheet H-3 Part I Date/Time Prepared: 1/28/2016 2:12 pm

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	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	380,501	1.00
2.00	Physical Therapy	64,303	2.00
3.00	Occupational Therapy	32,371	3.00
4.00	Speech Pathology	837	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	12,111	6.00
7.00	Total (sum of lines 1-6)	490,123	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
9.00	Physical Therapy		9.00
10.00	Occupational Therapy		10.00
11.00	Speech Pathology		11.00
12.00	Medical Social Services		12.00
13.00	Home Health Aide		13.00
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet H-3 Part II | Date/Time Prepared: 1/28/2016 2:12 pm

HHA CCN: 147622 | Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.598182	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.190046	4,955	942	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	1.093259	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140019 | Period: From 09/01/2014 To 08/31/2015 | Worksheet H-4 Part I-II

HHA CCN: 147622 | Date/Time Prepared: 1/28/2016 2:12 pm

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	363,326	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	29,264	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	6,378	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,035	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	10,997	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	411,000	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	411,000	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	411,000	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	411,000	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	411,000	31.00
31.01	Sequestration adjustment (see instructions)	0	8,139	31.01
32.00	Interim payments (see instructions)	0	402,861	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 140019 HHA CCN: 147622

Period: From 09/01/2014 To 08/31/2015

Worksheet H-5

Date/Time Prepared: 1/28/2016 2:12 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		402,861	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		402,861	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		402,861	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140019	Period: From 09/01/2014 To 08/31/2015	Worksheet L Parts I-III Date/Time Prepared: 1/28/2016 2:12 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	84,786	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	0	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	4.33	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	84,786	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

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

Provider CCN: 140019 Component CCN: 143446 | Period: From 09/01/2014 To 08/31/2015 | Worksheet M-1 | Date/Time Prepared: 1/28/2016 2:12 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	356,218	0	356,218	-943	355,275	1.00
2.00	Physician Assistant	105,045	0	105,045	0	105,045	2.00
3.00	Nurse Practitioner	84,657	0	84,657	0	84,657	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	131,583	0	131,583	0	131,583	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	677,503	0	677,503	-943	676,560	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	7,754	7,754	0	7,754	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	4,233	4,233	0	4,233	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	11,987	11,987	0	11,987	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	677,503	11,987	689,490	-943	688,547	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	667	667	0	667	29.00
30.00	Administrative Costs	104,170	24,533	128,703	50,440	179,143	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	104,170	25,200	129,370	50,440	179,810	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	781,673	37,187	818,860	49,497	868,357	32.00

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

Provider CCN: 140019 | Component CCN: 143446 | Period: From 09/01/2014 To 08/31/2015 | Worksheet M-1 | Date/Time Prepared: 1/28/2016 2:12 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	355,275		1.00
2.00	Physician Assistant	0	105,045		2.00
3.00	Nurse Practitioner	0	84,657		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	131,583		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	676,560		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	7,754		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	4,233		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	11,987		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	688,547		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	667		29.00
30.00	Administrative Costs	0	179,143		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	179,810		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	868,357		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140019 Component CCN: 143446 | Period: From 09/01/2014 To 08/31/2015 | Worksheet M-2 Date/Time Prepared: 1/28/2016 2:12 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.96	3,111	4,200	4,032		1.00
2.00	Physician Assistant	1.07	2,174	2,100	2,247		2.00
3.00	Nurse Practitioner	0.66	1,795	2,100	1,386		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.69	7,080		7,665	7,665	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	2.69	7,080			7,665	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)					688,547	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					688,547	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					179,810	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					718,065	15.00
16.00	Total overhead (sum of lines 14 and 15)					897,875	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					897,875	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					897,875	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,586,422	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 140019 Component CCN: 143446	Period: From 09/01/2014 To 08/31/2015	Worksheet M-3 Date/Time Prepared: 1/28/2016 2:12 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,586,422	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		3,449	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,582,973	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		7,665	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)		7,665	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		206.52	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	206.52	206.52	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,188	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	451,866	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) *		451,866	16.00
16.01	Total program charges (see instructions)(from contractor's records)		208,654	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		349,418	16.04
16.05	Total program cost (see instructions)		349,418	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		15,093	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		38,712	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		349,418	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,046	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		351,464	22.00
23.00	Allowable bad debts (see instructions)		9,803	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		7,450	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		9,803	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)		358,914	26.00
26.01	Sequestration adjustment (see instructions)		7,178	26.01
27.00	Interim payments		266,026	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)		85,710	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: 140019 | Component CCN: 143446 | Period: From 09/01/2014 To 08/31/2015 | Worksheet M-4 | Date/Time Prepared: 1/28/2016 2:12 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	676,560	676,560	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000054	0.000326	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	37	221	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	662	577	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	699	798	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	688,547	688,547	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	897,875	897,875	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001015	0.001159	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	911	1,041	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,610	1,839	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	10	60	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	161.00	30.65	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	3	51	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	483	1,563	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)		3,449	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)		2,046	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140019 Component CCN: 143446	Period: From 09/01/2014 To 08/31/2015	Worksheet M-5 Date/Time Prepared: 1/28/2016 2:12 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		280,776	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		03/31/2015	7,998	3.50
3.51		08/27/2015	6,752	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-14,750	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		266,026	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		85,710	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		351,736	7.00

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