This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140294	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/25/2016 1:09 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/25/2016 Time: 1:09 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by CROSSROADS COMMUNITY HOSPITAL (140294) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 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	2,674	36,096	-13,434	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-25,243		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-72,854		0	10.01
200.00	Total	0	2,674	-62,001	-13,434	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2016 1:06 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8 DOCTORS PARK ROAD	PO Box:			1.00
2.00	City: MT VERNON	State: IL	Zip Code: 62864	County: JEFFERSON	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	CROSSROADS COMMUNITY HOSPITAL	140294	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	CROSSROADS COMMUNITY HOSPITAL	14U294	99914		04/12/1989	N	P	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	CROSSROADS FAMILY MED OF MT. VERNON	148524	99914		07/19/2013	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	CROSSROADS FAMILY MED OF WAYNE CITY	148523	99914		07/19/2013	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	4		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	466	54	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2016 1:06 pm

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	1		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.	01/01/2015	12/31/2015	38.00

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2016 1:06 pm

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/25/2016 1:06 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, 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)			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.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	20,558	260,279	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	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	449008	140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: COMMUNITY HEALTH SYSTEM PROFESSIONAL	Contractor's Name: WISCONSIN PHYSICIAN SERVICES	Contractor's Number: 52280	141.00
142.00	Street: 4000 MERIDIAN BLVD	PO Box:		142.00
143.00	City: FRANKLIN	State: TN	Zip Code: 37067	143.00

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

		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.	Y		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: 140294	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/25/2016 1:06 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)	01/01/2015	03/31/2015	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: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2016 1:06 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		N		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for 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	04/04/2016	Y
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
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2016 1:06 pm

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MARK	SHROUT	41.00
42.00	Enter the employer/company name of the cost report preparer.	QHC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	615-221-3660	MARK_SHROUT@QUORUMHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/25/2016 1:06 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	04/04/2016			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/25/2016 1:06 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	40	14,600	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		40	14,600	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	7	2,555	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		47	17,155	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		47				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2016 1:06 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)	1,700	496	2,950			1.00
2.00	HMO and other (see instructions)	200	6				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,700	496	2,950			7.00
8.00	INTENSIVE CARE UNIT	127	18	294			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)	1,827	514	3,244	0.00	187.25	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	943	0	4,380	0.00	6.65	26.00
26.01	RURAL HEALTH CLINIC II	1,019	0	5,079	0.00	3.21	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	197.11	27.00
28.00	Observation Bed Days		0	910			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/25/2016 1:06 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	569	200	1,078	1.00
2.00	HMO and other (see instructions)			56	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	569	200	1,078	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2016 1:06 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	10,607,499	0	10,607,499	410,000.06	25.87	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		268,734	0	268,734	3,466.28	77.53	5.00
6.00	Non-physician-Part B		136,621	0	136,621	8,623.64	15.84	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)		305,940	79,043	384,983	11,991.54	32.10	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		165,043	0	165,043	2,823.25	58.46	11.00
12.00	Contract labor: Top level management and other management and administrative services		90,857	0	90,857	1,130.50	80.37	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		810,964	0	810,964	16,102.00	50.36	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		3,104,996	0	3,104,996			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		107,231	0	107,231			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		42,207	0	42,207			23.00
24.00	Wage-related costs (RHC/FQHC)		62,753	0	62,753			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	117,756	0	117,756	4,163.00	28.29	26.00
27.00	Administrative & General	5.00	1,649,181	-79,043	1,570,138	54,286.24	28.92	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	148,735	0	148,735	6,374.00	23.33	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	234,865	0	234,865	19,487.57	12.05	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	232,258	-105,762	126,496	9,164.72	13.80	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	105,762	105,762	7,662.47	13.80	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	754,903	0	754,903	21,756.87	34.70	38.00
39.00	Central Services and Supply	14.00	153,585	0	153,585	8,773.70	17.51	39.00
40.00	Pharmacy	15.00	390,029	0	390,029	6,501.50	59.99	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part II Date/Time Prepared: 5/25/2016 1:06 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	272,155	0	272,155	16,058.46	16.95	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part III Date/Time Prepared: 5/25/2016 1:06 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)		10,202,144	0	10,202,144	397,910.14	25.64	1.00
2.00	Excluded area salaries (see instructions)		305,940	79,043	384,983	11,991.54	32.10	2.00
3.00	Subtotal salaries (line 1 minus line 2)		9,896,204	-79,043	9,817,161	385,918.60	25.44	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,066,864	0	1,066,864	20,055.75	53.19	4.00
5.00	Subtotal wage-related costs (see inst.)		3,104,996	0	3,104,996	0.00	31.63	5.00
6.00	Total (sum of lines 3 thru 5)		14,068,064	-79,043	13,989,021	405,974.35	34.46	6.00
7.00	Total overhead cost (see instructions)		3,953,467	-79,043	3,874,424	154,228.53	25.12	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 5/25/2016 1:06 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	165,355	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	1,961,646	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	22,303	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	15,489	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	837	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	7,508	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	233,354	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	586,794	17.00
18.00	Medicare Taxes - Employers Portion Only	137,234	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	77,206	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,207,726	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS OTHER BFTS	109,462	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part V | Date/Time Prepared: 5/25/2016 1:06 pm

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

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

Provider CCN: 140294 | Component CCN: 148524 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-8 | Date/Time Prepared: 5/25/2016 1:06 pm

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

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

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

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

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

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

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		JEFFERSON				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	16:30	08:00	16:30	08:00	16:30	11.00

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

Provider CCN: 140294
Component CCN: 148524

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-8
Date/Time Prepared:
5/25/2016 1:06 pm

Rural Health Clinic (RHC) I

Cost

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

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

Provider CCN: 140294 Component CCN: 148523 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-8 | Date/Time Prepared: 5/25/2016 1:06 pm

		Rural Health Clinic (RHC) II	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1209 W ROBINSON	1.00
		City: 1.00	State: 2.00	ZIP Code: 3.00
2.00	City, State, ZIP Code, County	WAYNE CITY	IL	62864	2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award: 1.00	Date: 2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

		Sunday		Monday		Tuesday	
		from: 1.00	to: 2.00	from: 3.00	to: 4.00	from: 5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	16:30	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?						12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00

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

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

			County: 4.00				
2.00	City, State, ZIP Code, County		WAYNE				2.00
		Tuesday: to 6.00	Wednesday: from 7.00	to 8.00	Thursday: from 9.00	to 10.00	
	Facility hours of operations (1)						
11.00	Clinic	16:30	08:00	16:30	08:00	12:00	11.00

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

Provider CCN: 140294
Component CCN: 148523

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-8

Date/Time Prepared:
5/25/2016 1:06 pm

Rural Health Clinic (RHC) II

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 5/25/2016 1:06 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)	0.141462	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,435,567	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,787,675	5.00
6.00	Medicaid charges	47,169,947	6.00
7.00	Medicaid cost (line 1 times line 6)	6,672,755	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)	2,449,513	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	160	9.00
10.00	Stand-alone SCHIP charges	8,393	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	1,187	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	1,027	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)	310	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	1,217	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	172	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)	2,450,540	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	506,218	43,096	549,314	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	71,611	6,096	77,707	21.00
22.00	Partial payment by patients approved for charity care	250	0	250	22.00
23.00	Cost of charity care (line 21 minus line 22)	71,361	6,096	77,457	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)	1,830,636	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	250,162	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,580,474	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	223,577	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	301,034	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,751,574	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/25/2016 1:06 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		765,865	765,865	-119,444	646,421	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2,122,907	2,122,907	793,458	2,916,365	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	117,756	25,615	143,371	2,475,222	2,618,593	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,649,181	10,531,111	12,180,292	-2,639,006	9,541,286	5.00
7.00	00700	OPERATION OF PLANT	148,735	1,209,703	1,358,438	-44,178	1,314,260	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	97,445	97,445	-830	96,615	8.00
9.00	00900	HOUSEKEEPING	234,865	77,400	312,265	0	312,265	9.00
10.00	01000	DIETARY	232,258	290,081	522,339	-238,305	284,034	10.00
11.00	01100	CAFETERIA	0	0	0	237,478	237,478	11.00
13.00	01300	NURSING ADMINISTRATION	754,903	84,549	839,452	-18,774	820,678	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	153,585	634,054	787,639	-376,704	410,935	14.00
15.00	01500	PHARMACY	390,029	686,640	1,076,669	-653,540	423,129	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	272,155	150,730	422,885	-5,721	417,164	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	942,337	653,116	1,595,453	-4,110	1,591,343	30.00
31.00	03100	INTENSIVE CARE UNIT	310,457	54,434	364,891	-2,059	362,832	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	907,233	3,122,988	4,030,221	-1,079,202	2,951,019	50.00
51.00	05100	RECOVERY ROOM	337,140	41,474	378,614	-378,614	0	51.00
53.00	05300	ANESTHESIOLOGY	0	557,312	557,312	0	557,312	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	482,724	802,555	1,285,279	-71,297	1,213,982	54.00
54.01	03630	ULTRA SOUND	119,110	49,014	168,124	-7,270	160,854	54.01
56.00	05600	RADIOISOTOPE	36,302	244,177	280,479	0	280,479	56.00
57.00	05700	CT SCAN	128,670	208,026	336,696	0	336,696	57.00
58.00	05800	MRI	0	143,257	143,257	0	143,257	58.00
60.00	06000	LABORATORY	706,758	604,809	1,311,567	-23,248	1,288,319	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	74,340	74,340	9,319	83,659	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	293,041	57,297	350,338	-16	350,322	65.00
66.00	06600	PHYSICAL THERAPY	395,065	182,769	577,834	-105,622	472,212	66.00
67.00	06700	OCCUPATIONAL THERAPY	172,586	17,444	190,030	0	190,030	67.00
68.00	06800	SPEECH PATHOLOGY	89,895	7,878	97,773	0	97,773	68.00
69.00	06900	ELECTROCARDIOLOGY	182,402	26,111	208,513	0	208,513	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	365,204	365,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,089,296	1,089,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	602,974	602,974	73.00
74.00	07400	RENAL DIALYSIS	0	15,251	15,251	0	15,251	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	45,342	12,657	57,999	-2,156	55,843	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	203,320	72,728	276,048	-4,347	271,701	88.00
88.01	08801	RURAL HEALTH CLINIC II	202,035	155,437	357,472	-5,938	351,534	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	793,675	1,441,981	2,235,656	-3,670	2,231,986	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,301,559	25,221,155	35,522,714	-211,100	35,311,614	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	263,784	194,086	457,870	-26,367	431,503	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	0	0	237,467	237,467	194.01
194.02	07954	SENIOR CIRCLE	42,156	16,984	59,140	0	59,140	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	10,607,499	25,432,225	36,039,724	0	36,039,724	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/25/2016 1:06 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	254,870	901,291		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-243,993	2,672,372		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,716	2,614,877		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,537,296	5,003,990		5.00
7.00	00700	OPERATION OF PLANT	-16,475	1,297,785		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	96,615		8.00
9.00	00900	HOUSEKEEPING	0	312,265		9.00
10.00	01000	DIETARY	0	284,034		10.00
11.00	01100	CAFETERIA	-60,918	176,560		11.00
13.00	01300	NURSING ADMINISTRATION	0	820,678		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	410,935		14.00
15.00	01500	PHARMACY	0	423,129		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-145	417,019		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-429,012	1,162,331		30.00
31.00	03100	INTENSIVE CARE UNIT	0	362,832		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-76,000	2,875,019		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	-330,918	226,394		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-251,037	962,945		54.00
54.01	03630	ULTRA SOUND	-2,492	158,362		54.01
56.00	05600	RADIOISOTOPE	-224	280,255		56.00
57.00	05700	CT SCAN	-29,512	307,184		57.00
58.00	05800	MRI	-210	143,047		58.00
60.00	06000	LABORATORY	-12,000	1,276,319		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	83,659		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	350,322		65.00
66.00	06600	PHYSICAL THERAPY	0	472,212		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	190,030		67.00
68.00	06800	SPEECH PATHOLOGY	0	97,773		68.00
69.00	06900	ELECTROCARDIOLOGY	0	208,513		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	365,204		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,089,296		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	602,974		73.00
74.00	07400	RENAL DIALYSIS	0	15,251		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	55,843		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-4,411	267,290		88.00
88.01	08801	RURAL HEALTH CLINIC II	-8,369	343,165		88.01
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-1,121,920	1,110,066		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,873,778	28,437,836		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-13,194	418,309		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07951	MARKETING	0	237,467		194.01
194.02	07954	SENIOR CIRCLE	0	59,140		194.02
194.03	07953	VACANT SPACE	0	0		194.03
194.04	07952	GUEST MEALS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-6,886,972	29,152,752		200.00

RECLASSIFICATIONS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/25/2016 1:06 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - EMPLOYEE BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,477,256	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	2,477,256	
	B - OXYGEN SUPPLY				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	44,212	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	44,212	
	C - RENTAL AND LEASE RECLASS				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	789,722	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
	TOTALS		0	789,722	
	D - OTHER CAPITAL COSTS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	54,453	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	115,708	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,736	3.00
	TOTALS		0	173,897	
	E - MARKETING				
1.00	MARKETING	194.01	79,043	158,424	1.00
	TOTALS		79,043	158,424	
	F - MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	320,992	1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,089,296	2.00
	TOTALS		0	1,410,288	
	G - COST OF DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	602,974	1.00
	TOTALS		0	602,974	
	H - BLOOD AND LAB				
1.00	LABORATORY	60.00	0	33,364	1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	42,683	0	2.00
	TOTALS		42,683	33,364	
	I - MISCELLANEOUS DEPARTMENTS				
1.00	OPERATING ROOM	50.00	337,140	41,474	1.00
	TOTALS		337,140	41,474	
	J - DIETARY				
1.00	CAFETERIA	11.00	105,762	131,716	1.00
	TOTALS		105,762	131,716	
500.00	Grand Total: Increases		564,628	5,863,327	500.00

RECLASSIFICATIONS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/25/2016 1:06 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,410,199	0		1.00
2.00	OPERATING ROOM	50.00	0	30,405	0		2.00
3.00	RURAL HEALTH CLINIC	88.00	0	4,347	0		3.00
4.00	RURAL HEALTH CLINIC II	88.01	0	5,938	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	26,367	0		5.00
	TOTALS		0	2,477,256			
	B - OXYGEN SUPPLY						
1.00	OPERATION OF PLANT	7.00	0	44,178	0		1.00
2.00	OPERATING ROOM	50.00	0	34	0		2.00
	TOTALS		0	44,212			
	C - RENTAL AND LEASE RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2,034	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	107,048	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	830	0		3.00
4.00	DIETARY	10.00	0	827	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	18,774	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	2,395	0		6.00
7.00	PHARMACY	15.00	0	50,566	0		7.00
8.00	MEDICAL RECORDS & LIBRARY	16.00	0	5,721	0		8.00
9.00	ADULTS & PEDIATRICS	30.00	0	4,110	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	2,059	0		10.00
11.00	OPERATING ROOM	50.00	0	391,398	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	71,297	0		12.00
13.00	ULTRA SOUND	54.01	0	7,270	0		13.00
14.00	LABORATORY	60.00	0	13,929	0		14.00
15.00	RESPIRATORY THERAPY	65.00	0	16	0		15.00
16.00	PHYSICAL THERAPY	66.00	0	105,622	0		16.00
17.00	SLEEP LAB	76.01	0	2,156	0		17.00
18.00	EMERGENCY	91.00	0	3,670	0		18.00
	TOTALS		0	789,722			
	D - OTHER CAPITAL COSTS						
1.00		0.00	0	0	12		1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	173,897	13		2.00
3.00		0.00	0	0	12		3.00
	TOTALS		0	173,897			
	E - MARKETING						
1.00	ADMINISTRATIVE & GENERAL	5.00	79,043	158,424	0		1.00
	TOTALS		79,043	158,424			
	F - MEDICAL SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	374,309	0		1.00
2.00	OPERATING ROOM	50.00	0	1,035,979	0		2.00
	TOTALS		0	1,410,288			
	G - COST OF DRUGS						
1.00	PHARMACY	15.00	0	602,974	0		1.00
	TOTALS		0	602,974			
	H - BLOOD AND LAB						
1.00	LABORATORY	60.00	42,683	0	0		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	33,364	0		2.00
	TOTALS		42,683	33,364			
	I - MISCELLANEOUS DEPARTMENTS						
1.00	RECOVERY ROOM	51.00	337,140	41,474	0		1.00
	TOTALS		337,140	41,474			
	J - DIETARY						
1.00	DIETARY	10.00	105,762	131,716	0		1.00
	TOTALS		105,762	131,716			
500.00	Grand Total: Decreases		564,628	5,863,327			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/25/2016 1:06 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	961,157	0	0	0	0	1.00
2.00	Land Improvements	411,367	0	0	0	0	2.00
3.00	Buildings and Fixtures	28,728,704	15,744	0	15,744	0	3.00
4.00	Building Improvements	5,753,603	0	0	0	0	4.00
5.00	Fixed Equipment	1,866,292	326,891	0	326,891	0	5.00
6.00	Movable Equipment	12,756,207	396,611	0	396,611	0	6.00
7.00	HIT designated Assets	4,786,211	1,353	0	1,353	0	7.00
8.00	Subtotal (sum of lines 1-7)	55,263,541	740,599	0	740,599	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	55,263,541	740,599	0	740,599	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	961,157	0	1.00
2.00	Land Improvements	411,367	0	2.00
3.00	Buildings and Fixtures	28,744,448	0	3.00
4.00	Building Improvements	5,753,603	0	4.00
5.00	Fixed Equipment	2,193,183	0	5.00
6.00	Movable Equipment	13,152,818	0	6.00
7.00	HIT designated Assets	4,787,564	0	7.00
8.00	Subtotal (sum of lines 1-7)	56,004,140	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	56,004,140	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/25/2016 1:06 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	765,865	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2,122,907	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,888,772	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	765,865		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	2,122,907		2.00
3.00	Total (sum of lines 1-2)	0	2,888,772		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/25/2016 1:06 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	35,870,575	0	35,870,575	0.640499	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	20,133,567	0	20,133,567	0.359501	0	2.00
3.00	Total (sum of lines 1-2)	56,004,142	0	56,004,142	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	894,492	-41,213	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,830,654	789,722	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,725,146	748,509	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	54,453	-173,897	167,456	901,291	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	48,260	3,736	0	0	2,672,372	2.00
3.00	Total (sum of lines 1-2)	48,260	58,189	-173,897	167,456	3,573,663	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/25/2016 1:06 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-90,952	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-624	CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,253,325			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	450,509			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-60,918	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-145	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	A	126,941	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	A	-296,529	CAP REL COSTS-MVBLE EQUIP	2.00	9	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	ADMIN & GENERAL ORGANIZATION COST	A	-201,150	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/25/2016 1:06 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	BAD DEBTS	A	-2,696,695	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02	MARKETING EXPENSE	A	-97,023	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	COUNTRY CLUB DUES	A	-680	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PHYSICIAN RECRUITING	A	-82,089	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	LOBBYING EXPENSE	A	-13,634	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	CHARITABLE EXPENSE	A	-6,790	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	SPECIAL EVENTS	A	-34,720	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	MEDICAL STAFF RELATIONS	A	-13,792	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	ILLINOIS PROVIDER TAX	A	-1,238,704	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	GIFT SHOP EXPENSE	A	-2,306	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11	NON-ALLOWABLE LEGAL FEES	A	-164,573	ADMINISTRATIVE & GENERAL	5.00	0	33.11
33.12			0		0.00	0	33.12
33.13	TELEPHONE BENEFIT COSTS	A	-3,716	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	TELEPHONE DEPRECIATION COST	A	-5,058	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.14
33.15	TELEVISION EXPENSE	A	-16,475	OPERATION OF PLANT	7.00	0	33.15
33.17	FITNESS REVENUE	B	-850	ADMINISTRATIVE & GENERAL	5.00	0	33.17
33.19	PHOTO COMMISSION	B	-150	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20	PHYSICIAN OFFICE BAD DEBT	A	-13,194	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.20
33.21	RENTAL INCOME	B	-41,213	CAP REL COSTS-BLDG & FIXT	1.00	10	33.21
33.22	OTHER MISCELLANEOUS REVENUE	B	-116,337	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23	RURAL HEALTH CLINIC II BAD DEBT	A	-8,369	RURAL HEALTH CLINIC II	88.01	0	33.23
33.24	RURAL HEALTH CLINIC III BAD DEBT	A	-4,411	RURAL HEALTH CLINIC	88.00	0	33.24
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,886,972				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-1 | Date/Time Prepared: 5/25/2016 1:06 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	DIRECT ALLOCATION - CAPITAL	141,717	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	DIRECT ALLOCATION - OPERATIN	57,835	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	PASI OPERATING COSTS	295,569	0	3.00
4.00	1.00	CAP REL COSTS-BLDG & FIXT	PASI CAPITAL COSTS - BLDG &	18,885	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	PASI CAPITAL COSTS - MOVEABL	2,758	0	4.01
4.02	1.00	CAP REL COSTS-BLDG & FIXT	NEW CAPITAL - BUILDING & FIX	6,854	0	4.02
4.03	2.00	CAP REL COSTS-MVBLE EQUIP	NEW CAPITAL - MOVABLE EQUIPM	45,502	0	4.03
4.04	5.00	ADMINISTRATIVE & GENERAL	NON-CAPITAL HOME OFFICE COST	656,461	0	4.04
4.05	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE COSTS	280,837	345,045	4.05
4.06	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXPENSE	0	-542,626	4.06
4.07	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	0	521,182	4.07
4.08	5.00	ADMINISTRATIVE & GENERAL	401K FEES	0	1,477	4.08
4.09	5.00	ADMINISTRATIVE & GENERAL	AUDIT FEES	0	20,828	4.09
4.10	5.00	ADMINISTRATIVE & GENERAL	CORPORATE OVERHEAD ALLOCATIO	0	473,544	4.10
4.11	1.00	CAP REL COSTS-BLDG & FIXT	PRE-ACQUISITION	1,686	0	4.11
4.12	2.00	CAP REL COSTS-MVBLE EQUIP	PRE-ACQUISITION	9,958	0	4.12
4.13	5.00	ADMINISTRATIVE & GENERAL	PRE-ACQUISITION	103,466	0	4.13
4.14	0.00			0	0	4.14
4.15	5.00	ADMINISTRATIVE & GENERAL	PPSI FEES	0	24,420	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	5.00	ADMINISTRATIVE & GENERAL	PASI COLLECTION FEES	0	265,147	4.18
4.19	5.00	ADMINISTRATIVE & GENERAL	EBOS FEES	0	15,914	4.19
4.20	5.00	ADMINISTRATIVE & GENERAL	PASI LIEN UNIT COLLECTION FE	0	46,088	4.20
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,621,528	1,171,019	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					
6.00	B		0.00	CHSPSC	100.00	6.00
7.00	B		0.00	PASI	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 140294	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 5/25/2016 1:06 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	141,717	14		1.00
2.00	57,835	0		2.00
3.00	295,569	0		3.00
4.00	18,885	14		4.00
4.01	2,758	11		4.01
4.02	6,854	14		4.02
4.03	45,502	11		4.03
4.04	656,461	0		4.04
4.05	-64,208	0		4.05
4.06	542,626	0		4.06
4.07	-521,182	0		4.07
4.08	-1,477	0		4.08
4.09	-20,828	0		4.09
4.10	-473,544	0		4.10
4.11	1,686	9		4.11
4.12	9,958	9		4.12
4.13	103,466	0		4.13
4.14	0	0		4.14
4.15	-24,420	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	-265,147	0		4.18
4.19	-15,914	0		4.19
4.20	-46,088	0		4.20
5.00	450,509			5.00

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

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

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

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

6.00	CHAIN OPERATOR		6.00
7.00	COLLECTION SERV		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/25/2016 1:06 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	429,012	429,012	0	0	0	1.00
2.00	50.00	OPERATING ROOM	76,000	76,000	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	330,918	330,918	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	251,037	251,037	0	0	0	4.00
5.00	54.01	ULTRA SOUND	2,492	2,492	0	0	0	5.00
6.00	56.00	RADIOISOTOPE	224	224	0	0	0	6.00
7.00	57.00	CT SCAN	29,512	29,512	0	0	0	7.00
8.00	58.00	MRI	210	210	0	0	0	8.00
9.00	60.00	LABORATORY	12,000	12,000	0	0	0	9.00
10.00	91.00	EMERGENCY	1,121,920	1,121,920	0	0	0	10.00
200.00			2,253,325	2,253,325	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	54.01	ULTRA SOUND	0	0	0	0	0	5.00
6.00	56.00	RADIOISOTOPE	0	0	0	0	0	6.00
7.00	57.00	CT SCAN	0	0	0	0	0	7.00
8.00	58.00	MRI	0	0	0	0	0	8.00
9.00	60.00	LABORATORY	0	0	0	0	0	9.00
10.00	91.00	EMERGENCY	0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	429,012		1.00
2.00	50.00	OPERATING ROOM	0	0	0	76,000		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	330,918		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	251,037		4.00
5.00	54.01	ULTRA SOUND	0	0	0	2,492		5.00
6.00	56.00	RADIOISOTOPE	0	0	0	224		6.00
7.00	57.00	CT SCAN	0	0	0	29,512		7.00
8.00	58.00	MRI	0	0	0	210		8.00
9.00	60.00	LABORATORY	0	0	0	12,000		9.00
10.00	91.00	EMERGENCY	0	0	0	1,121,920		10.00
200.00			0	0	0	2,253,325		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/25/2016 1:06 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	901,291	901,291				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2,672,372		2,672,372			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,614,877	5,567	16,507	2,636,951		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,003,990	106,318	315,237	394,707	5,820,252	5.00
7.00	00700	OPERATION OF PLANT	1,297,785	170,234	504,753	37,390	2,010,162	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	96,615	3,818	11,319	0	111,752	8.00
9.00	00900	HOUSEKEEPING	312,265	28,701	85,100	59,041	485,107	9.00
10.00	01000	DIETARY	284,034	26,820	79,522	31,799	422,175	10.00
11.00	01100	CAFETERIA	176,560	0	0	26,587	203,147	11.00
13.00	01300	NURSING ADMINISTRATION	820,678	8,880	26,330	189,771	1,045,659	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	410,935	18,963	56,227	38,609	524,734	14.00
15.00	01500	PHARMACY	423,129	7,040	20,875	98,047	549,091	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	417,019	17,248	51,142	68,415	553,824	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,162,331	155,600	461,363	236,888	2,016,182	30.00
31.00	03100	INTENSIVE CARE UNIT	362,832	33,217	98,490	78,044	572,583	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,875,019	106,809	316,693	312,815	3,611,336	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	226,394	1,183	3,507	0	231,084	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	962,945	30,049	89,098	121,349	1,203,441	54.00
54.01	03630	ULTRA SOUND	158,362	3,513	10,417	29,942	202,234	54.01
56.00	05600	RADIOISOTOPE	280,255	2,953	8,756	9,126	301,090	56.00
57.00	05700	CT SCAN	307,184	0	0	32,346	339,530	57.00
58.00	05800	MRI	143,047	0	0	0	143,047	58.00
60.00	06000	LABORATORY	1,276,319	20,658	61,251	166,938	1,525,166	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	83,659	1,051	3,117	10,730	98,557	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	350,322	9,447	28,011	73,666	461,446	65.00
66.00	06600	PHYSICAL THERAPY	472,212	3,804	11,278	99,313	586,607	66.00
67.00	06700	OCCUPATIONAL THERAPY	190,030	0	0	43,385	233,415	67.00
68.00	06800	SPEECH PATHOLOGY	97,773	0	0	22,598	120,371	68.00
69.00	06900	ELECTROCARDIOLOGY	208,513	0	0	45,853	254,366	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	365,204	0	0	0	365,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,089,296	0	0	0	1,089,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	602,974	0	0	0	602,974	73.00
74.00	07400	RENAL DIALYSIS	15,251	1,611	4,778	0	21,640	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	55,843	11,501	34,101	11,398	112,843	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	267,290	0	0	51,111	318,401	88.00
88.01	08801	RURAL HEALTH CLINIC II	343,165	0	0	50,788	393,953	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,110,066	43,446	128,818	199,517	1,481,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,437,836	818,431	2,426,690	2,540,173	28,012,516	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,663	7,895	0	10,558	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	418,309	2,587	7,669	66,311	494,876	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	237,467	1,418	4,204	19,870	262,959	194.01
194.02	07954	SENIOR CIRCLE	59,140	9,371	27,786	10,597	106,894	194.02
194.03	07953	VACANT SPACE	0	66,821	198,128	0	264,949	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	29,152,752	901,291	2,672,372	2,636,951	29,152,752	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/25/2016 1:06 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,820,252					5.00
7.00	00700	OPERATION OF PLANT	501,431	2,511,593				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	27,876	15,485	155,113			8.00
9.00	00900	HOUSEKEEPING	121,009	116,422	0	722,538		9.00
10.00	01000	DIETARY	105,311	108,791	0	33,032	669,309	10.00
11.00	01100	CAFETERIA	50,675	0	0	0	320,757	11.00
13.00	01300	NURSING ADMINISTRATION	260,838	36,021	0	10,937	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	130,894	76,922	0	23,356	0	14.00
15.00	01500	PHARMACY	136,970	28,558	0	8,671	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	138,150	69,965	0	21,243	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	502,933	631,175	51,186	191,639	284,016	30.00
31.00	03100	INTENSIVE CARE UNIT	142,830	134,740	9,307	40,911	28,309	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	900,845	433,257	31,023	131,549	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	57,643	4,797	0	1,457	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	300,196	121,892	9,307	37,010	0	54.00
54.01	03630	ULTRA SOUND	50,447	14,251	0	4,327	0	54.01
56.00	05600	RADIOISOTOPE	75,106	11,979	0	3,637	0	56.00
57.00	05700	CT SCAN	84,695	0	0	0	0	57.00
58.00	05800	MRI	35,683	0	0	0	0	58.00
60.00	06000	LABORATORY	380,450	83,796	0	25,443	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	24,585	4,264	0	1,295	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	115,107	38,321	4,654	11,635	0	65.00
66.00	06600	PHYSICAL THERAPY	146,328	15,429	0	4,685	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	58,225	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	30,026	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	63,451	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	91,099	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	271,723	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	150,411	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	5,398	6,536	0	1,985	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	28,148	46,653	0	14,165	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	79,424	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	98,271	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	369,644	176,231	49,636	53,509	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,535,822	2,175,485	155,113	620,486	633,082	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,634	10,801	0	3,279	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	123,446	10,492	0	3,186	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	65,595	5,751	0	1,746	0	194.01
194.02	07954	SENIOR CIRCLE	26,664	38,012	0	11,542	0	194.02
194.03	07953	VACANT SPACE	66,091	271,052	0	82,299	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	36,227	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,820,252	2,511,593	155,113	722,538	669,309	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/25/2016 1:06 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	574,579					11.00
13.00	01300	NURSING ADMINISTRATION	43,354	1,396,809				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,491	0	773,397			14.00
15.00	01500	PHARMACY	12,973	129,662	977	866,902		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	31,997	0	1,739	0	816,918	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	84,013	313,272	19,191	0	25,147	30.00
31.00	03100	INTENSIVE CARE UNIT	22,216	103,209	5,629	0	3,386	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	89,649	413,684	235,579	0	150,347	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	3,072	0	72,440	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	37,219	0	8,065	0	34,471	54.00
54.01	03630	ULTRA SOUND	9,118	0	636	0	12,717	54.01
56.00	05600	RADIOISOTOPE	3,150	0	743	0	9,987	56.00
57.00	05700	CT SCAN	11,647	0	10,543	0	127,991	57.00
58.00	05800	MRI	0	0	495	0	13,746	58.00
60.00	06000	LABORATORY	59,145	0	92,173	0	144,465	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,813	0	0	0	2,257	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	22,962	97,419	5,829	0	9,155	65.00
66.00	06600	PHYSICAL THERAPY	24,619	0	2,927	0	14,109	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,077	0	683	0	8,266	67.00
68.00	06800	SPEECH PATHOLOGY	3,564	0	119	0	1,253	68.00
69.00	06900	ELECTROCARDIOLOGY	18,154	60,638	471	0	19,872	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	79,316	0	5,482	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	269,160	0	33,085	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	866,902	31,858	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	63	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	3,606	15,074	887	0	3,015	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	8,823	0	1,282	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	4,844	0	2,315	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	59,725	263,851	18,315	0	90,209	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	567,492	1,396,809	770,216	866,902	816,918	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	3,274	0	452	0	0	194.01
194.02	07954	SENIOR CIRCLE	3,813	0	2,729	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	574,579	1,396,809	773,397	866,902	816,918	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/25/2016 1:06 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	4,118,754	0	4,118,754		30.00
31.00	03100	INTENSIVE CARE UNIT	1,063,120	0	1,063,120		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,997,269	0	5,997,269		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	370,493	0	370,493		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,751,601	0	1,751,601		54.00
54.01	03630	ULTRA SOUND	293,730	0	293,730		54.01
56.00	05600	RADIOISOTOPE	405,692	0	405,692		56.00
57.00	05700	CT SCAN	574,406	0	574,406		57.00
58.00	05800	MRI	192,971	0	192,971		58.00
60.00	06000	LABORATORY	2,310,638	0	2,310,638		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	134,771	0	134,771		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	766,528	0	766,528		65.00
66.00	06600	PHYSICAL THERAPY	794,704	0	794,704		66.00
67.00	06700	OCCUPATIONAL THERAPY	309,666	0	309,666		67.00
68.00	06800	SPEECH PATHOLOGY	155,333	0	155,333		68.00
69.00	06900	ELECTROCARDIOLOGY	416,952	0	416,952		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	541,101	0	541,101		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,663,264	0	1,663,264		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,652,145	0	1,652,145		73.00
74.00	07400	RENAL DIALYSIS	35,622	0	35,622		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	224,391	0	224,391		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	407,930	0	407,930		88.00
88.01	08801	RURAL HEALTH CLINIC II	499,383	0	499,383		88.01
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	2,562,967	0	2,562,967		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,243,431	0	27,243,431		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,272	0	27,272		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	632,000	0	632,000		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	339,777	0	339,777		194.01
194.02	07954	SENIOR CIRCLE	189,654	0	189,654		194.02
194.03	07953	VACANT SPACE	684,391	0	684,391		194.03
194.04	07952	GUEST MEALS	36,227	0	36,227		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	29,152,752	0	29,152,752		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/25/2016 1:06 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	5,567	16,507	22,074	22,074	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	106,318	315,237	421,555	3,306	5.00
7.00	00700	OPERATION OF PLANT	0	170,234	504,753	674,987	313	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	3,818	11,319	15,137	0	8.00
9.00	00900	HOUSEKEEPING	0	28,701	85,100	113,801	494	9.00
10.00	01000	DIETARY	0	26,820	79,522	106,342	266	10.00
11.00	01100	CAFETERIA	0	0	0	0	223	11.00
13.00	01300	NURSING ADMINISTRATION	0	8,880	26,330	35,210	1,588	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,963	56,227	75,190	323	14.00
15.00	01500	PHARMACY	0	7,040	20,875	27,915	821	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,248	51,142	68,390	573	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	155,600	461,363	616,963	1,983	30.00
31.00	03100	INTENSIVE CARE UNIT	0	33,217	98,490	131,707	653	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	106,809	316,693	423,502	2,618	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	1,183	3,507	4,690	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,049	89,098	119,147	1,016	54.00
54.01	03630	ULTRA SOUND	0	3,513	10,417	13,930	251	54.01
56.00	05600	RADIOISOTOPE	0	2,953	8,756	11,709	76	56.00
57.00	05700	CT SCAN	0	0	0	0	271	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	20,658	61,251	81,909	1,397	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,051	3,117	4,168	90	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	9,447	28,011	37,458	617	65.00
66.00	06600	PHYSICAL THERAPY	0	3,804	11,278	15,082	831	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	363	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	189	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	384	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,611	4,778	6,389	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	11,501	34,101	45,602	95	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	428	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	425	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	43,446	128,818	172,264	1,670	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	818,431	2,426,690	3,245,121	21,264	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,663	7,895	10,558	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,587	7,669	10,256	555	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	1,418	4,204	5,622	166	194.01
194.02	07954	SENIOR CIRCLE	0	9,371	27,786	37,157	89	194.02
194.03	07953	VACANT SPACE	0	66,821	198,128	264,949	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	901,291	2,672,372	3,573,663	22,074	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/25/2016 1:06 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	424,861					5.00
7.00	00700	OPERATION OF PLANT	36,603	711,903				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,035	4,389	21,561			8.00
9.00	00900	HOUSEKEEPING	8,833	32,999	0	156,127		9.00
10.00	01000	DIETARY	7,687	30,836	0	7,138	152,269	10.00
11.00	01100	CAFETERIA	3,699	0	0	0	72,973	11.00
13.00	01300	NURSING ADMINISTRATION	19,040	10,210	0	2,363	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,555	21,803	0	5,047	0	14.00
15.00	01500	PHARMACY	9,998	8,095	0	1,874	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	10,085	19,831	0	4,590	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	36,713	178,906	7,114	41,410	64,614	30.00
31.00	03100	INTENSIVE CARE UNIT	10,426	38,192	1,294	8,840	6,440	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,759	122,805	4,312	28,425	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	4,208	1,360	0	315	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,913	34,550	1,294	7,997	0	54.00
54.01	03630	ULTRA SOUND	3,682	4,039	0	935	0	54.01
56.00	05600	RADIOISOTOPE	5,483	3,395	0	786	0	56.00
57.00	05700	CT SCAN	6,183	0	0	0	0	57.00
58.00	05800	MRI	2,605	0	0	0	0	58.00
60.00	06000	LABORATORY	27,772	23,752	0	5,498	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,795	1,209	0	280	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	8,402	10,862	647	2,514	0	65.00
66.00	06600	PHYSICAL THERAPY	10,682	4,373	0	1,012	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,250	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,192	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	4,632	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,650	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,835	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,980	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	394	1,853	0	429	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	2,055	13,224	0	3,061	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,798	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,173	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	26,983	49,952	6,900	11,562	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	404,100	616,635	21,561	134,076	144,027	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	192	3,061	0	709	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,011	2,974	0	688	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	4,788	1,630	0	377	0	194.01
194.02	07954	SENIOR CIRCLE	1,946	10,774	0	2,494	0	194.02
194.03	07953	VACANT SPACE	4,824	76,829	0	17,783	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	8,242	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	424,861	711,903	21,561	156,127	152,269	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/25/2016 1:06 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	76,895					11.00
13.00	01300	NURSING ADMINISTRATION	5,802	74,213				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,341	0	114,259			14.00
15.00	01500	PHARMACY	1,736	6,889	144	57,472		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,282	0	257	0	108,008	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,243	16,644	2,835	0	3,326	30.00
31.00	03100	INTENSIVE CARE UNIT	2,973	5,484	832	0	448	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	11,998	21,978	34,804	0	19,854	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	454	0	9,580	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,981	0	1,192	0	4,559	54.00
54.01	03630	ULTRA SOUND	1,220	0	94	0	1,682	54.01
56.00	05600	RADIOISOTOPE	422	0	110	0	1,321	56.00
57.00	05700	CT SCAN	1,559	0	1,558	0	16,927	57.00
58.00	05800	MRI	0	0	73	0	1,818	58.00
60.00	06000	LABORATORY	7,915	0	13,617	0	19,105	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	510	0	0	0	298	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3,073	5,176	861	0	1,211	65.00
66.00	06600	PHYSICAL THERAPY	3,295	0	432	0	1,866	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,215	0	101	0	1,093	67.00
68.00	06800	SPEECH PATHOLOGY	477	0	18	0	166	68.00
69.00	06900	ELECTROCARDIOLOGY	2,429	3,222	70	0	2,628	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	11,718	0	725	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	39,763	0	4,375	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	57,472	4,213	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	8	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	483	801	131	0	399	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,303	0	170	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	716	0	306	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	7,993	14,019	2,706	0	11,930	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	75,947	74,213	113,789	57,472	108,008	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	438	0	67	0	0	194.01
194.02	07954	SENIOR CIRCLE	510	0	403	0	0	194.02
194.03	07953	VACANT SPACE	0	0	0	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	76,895	74,213	114,259	57,472	108,008	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/25/2016 1:06 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	981,751	0	981,751		30.00
31.00	03100	INTENSIVE CARE UNIT	207,289	0	207,289		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	736,055	0	736,055		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	20,607	0	20,607		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	196,649	0	196,649		54.00
54.01	03630	ULTRA SOUND	25,833	0	25,833		54.01
56.00	05600	RADIOISOTOPE	23,302	0	23,302		56.00
57.00	05700	CT SCAN	26,498	0	26,498		57.00
58.00	05800	MRI	4,496	0	4,496		58.00
60.00	06000	LABORATORY	180,965	0	180,965		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,350	0	8,350		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	70,821	0	70,821		65.00
66.00	06600	PHYSICAL THERAPY	37,573	0	37,573		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,022	0	7,022		67.00
68.00	06800	SPEECH PATHOLOGY	3,042	0	3,042		68.00
69.00	06900	ELECTROCARDIOLOGY	13,365	0	13,365		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,093	0	19,093		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,973	0	63,973		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,665	0	72,665		73.00
74.00	07400	RENAL DIALYSIS	9,073	0	9,073		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	65,851	0	65,851		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	7,699	0	7,699		88.00
88.01	08801	RURAL HEALTH CLINIC II	8,620	0	8,620		88.01
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	305,979	0	305,979		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,096,571	0	3,096,571		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,520	0	14,520		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	23,484	0	23,484		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194.00
194.01	07951	MARKETING	13,088	0	13,088		194.01
194.02	07954	SENIOR CIRCLE	53,373	0	53,373		194.02
194.03	07953	VACANT SPACE	364,385	0	364,385		194.03
194.04	07952	GUEST MEALS	8,242	0	8,242		194.04
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	3,573,663	0	3,573,663		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/25/2016 1:06 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	130,322					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		130,322				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	805	805	10,489,743			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,373	15,373	1,570,138	-5,820,252	23,332,500	5.00
7.00	00700	OPERATION OF PLANT	24,615	24,615	148,735	0	2,010,162	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	552	0	0	111,752	8.00
9.00	00900	HOUSEKEEPING	4,150	4,150	234,865	0	485,107	9.00
10.00	01000	DIETARY	3,878	3,878	126,496	0	422,175	10.00
11.00	01100	CAFETERIA	0	0	105,762	0	203,147	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	1,284	754,903	0	1,045,659	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	2,742	153,585	0	524,734	14.00
15.00	01500	PHARMACY	1,018	1,018	390,029	0	549,091	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	2,494	272,155	0	553,824	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,499	22,499	942,337	0	2,016,182	30.00
31.00	03100	INTENSIVE CARE UNIT	4,803	4,803	310,457	0	572,583	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,444	15,444	1,244,373	0	3,611,336	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	171	171	0	0	231,084	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	4,345	482,724	0	1,203,441	54.00
54.01	03630	ULTRA SOUND	508	508	119,110	0	202,234	54.01
56.00	05600	RADIOISOTOPE	427	427	36,302	0	301,090	56.00
57.00	05700	CT SCAN	0	0	128,670	0	339,530	57.00
58.00	05800	MRI	0	0	0	0	143,047	58.00
60.00	06000	LABORATORY	2,987	2,987	664,075	0	1,525,166	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	152	42,683	0	98,557	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,366	1,366	293,041	0	461,446	65.00
66.00	06600	PHYSICAL THERAPY	550	550	395,065	0	586,607	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	172,586	0	233,415	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	89,895	0	120,371	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	182,402	0	254,366	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	365,204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,089,296	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	602,974	73.00
74.00	07400	RENAL DIALYSIS	233	233	0	0	21,640	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,663	1,663	45,342	0	112,843	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	203,320	0	318,401	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	202,035	0	393,953	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,282	6,282	793,675	0	1,481,847	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	118,341	118,341	10,104,760	-5,820,252	22,192,264	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	385	0	0	10,558	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	374	263,784	0	494,876	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	205	205	79,043	0	262,959	194.01
194.02	07954	SENIOR CIRCLE	1,355	1,355	42,156	0	106,894	194.02
194.03	07953	VACANT SPACE	9,662	9,662	0	0	264,949	194.03
194.04	07952	GUEST MEALS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	901,291	2,672,372	2,636,951		5,820,252	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.915878	20.505916	0.251384		0.249448	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			22,074		424,861	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002104		0.018209	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/25/2016 1:06 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	89,529					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	552	177,553				8.00
9.00	00900	HOUSEKEEPING	4,150	0	84,827			9.00
10.00	01000	DIETARY	3,878	0	3,878	20,877		10.00
11.00	01100	CAFETERIA	0	0	0	10,005	13,863	11.00
13.00	01300	NURSING ADMINISTRATION	1,284	0	1,284	0	1,046	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,742	0	2,742	0	422	14.00
15.00	01500	PHARMACY	1,018	0	1,018	0	313	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,494	0	2,494	0	772	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,499	58,592	22,499	8,859	2,027	30.00
31.00	03100	INTENSIVE CARE UNIT	4,803	10,653	4,803	883	536	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	15,444	35,511	15,444	0	2,163	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	171	0	171	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,345	10,653	4,345	0	898	54.00
54.01	03630	ULTRA SOUND	508	0	508	0	220	54.01
56.00	05600	RADIOISOTOPE	427	0	427	0	76	56.00
57.00	05700	CT SCAN	0	0	0	0	281	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,987	0	2,987	0	1,427	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	152	0	152	0	92	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,366	5,327	1,366	0	554	65.00
66.00	06600	PHYSICAL THERAPY	550	0	550	0	594	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	219	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	86	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	438	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	233	0	233	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,663	0	1,663	0	87	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	6,282	56,817	6,282	0	1,441	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	77,548	177,553	72,846	19,747	13,692	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	385	0	385	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	374	0	374	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07951	MARKETING	205	0	205	0	79	194.01
194.02	07954	SENIOR CIRCLE	1,355	0	1,355	0	92	194.02
194.03	07953	VACANT SPACE	9,662	0	9,662	0	0	194.03
194.04	07952	GUEST MEALS	0	0	0	1,130	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,511,593	155,113	722,538	669,309	574,579	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.053402	0.873615	8.517783	32.059635	41.446945	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	711,903	21,561	156,127	152,269	76,895	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.951647	0.121434	1.840534	7.293625	5.546779	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/25/2016 1:06 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	4,201,656					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,129,942				14.00
15.00	01500	PHARMACY	390,029	3,953	602,974			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,036	0	192,584,342		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	942,337	77,667	0	5,928,146		30.00
31.00	03100	INTENSIVE CARE UNIT	310,457	22,782	0	798,222		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,244,373	953,391	0	35,448,346		50.00
51.00	05100	RECOVERY ROOM	0	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	12,432	0	17,076,909		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	32,641	0	8,126,179		54.00
54.01	03630	ULTRA SOUND	0	2,575	0	2,997,873		54.01
56.00	05600	RADIOISOTOPE	0	3,005	0	2,354,248		56.00
57.00	05700	CT SCAN	0	42,666	0	30,172,211		57.00
58.00	05800	MRI	0	2,002	0	3,240,472		58.00
60.00	06000	LABORATORY	0	373,027	0	34,055,915		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	531,992		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	293,041	23,588	0	2,158,215		65.00
66.00	06600	PHYSICAL THERAPY	0	11,844	0	3,325,988		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,763	0	1,948,585		67.00
68.00	06800	SPEECH PATHOLOGY	0	480	0	295,437		68.00
69.00	06900	ELECTROCARDIOLOGY	182,402	1,908	0	4,684,478		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	320,992	0	1,292,347		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,089,297	0	7,799,324		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	602,974	7,510,171		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	14,850		74.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	45,342	3,589	0	710,640		76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	35,707	0	302,259		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	19,603	0	545,801		88.01
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	793,675	74,119	0	21,265,734		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,201,656	3,117,067	602,974	192,584,342		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.00
194.01	07951	MARKETING	0	1,829	0	0		194.01
194.02	07954	SENIOR CIRCLE	0	11,046	0	0		194.02
194.03	07953	VACANT SPACE	0	0	0	0		194.03
194.04	07952	GUEST MEALS	0	0	0	0		194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,396,809	773,397	866,902	816,918		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.332442	0.247096	1.437710	0.004242		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	74,213	114,259	57,472	108,008		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.017663	0.036505	0.095314	0.000561		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 1:06 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	4,118,754		4,118,754	0	4,118,754	30.00
31.00	03100	INTENSIVE CARE UNIT	1,063,120		1,063,120	0	1,063,120	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,997,269		5,997,269	0	5,997,269	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	370,493		370,493	0	370,493	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,751,601		1,751,601	0	1,751,601	54.00
54.01	03630	ULTRA SOUND	293,730		293,730	0	293,730	54.01
56.00	05600	RADIOISOTOPE	405,692		405,692	0	405,692	56.00
57.00	05700	CT SCAN	574,406		574,406	0	574,406	57.00
58.00	05800	MRI	192,971		192,971	0	192,971	58.00
60.00	06000	LABORATORY	2,310,638		2,310,638	0	2,310,638	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	134,771		134,771	0	134,771	62.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	766,528	0	766,528	0	766,528	65.00
66.00	06600	PHYSICAL THERAPY	794,704	0	794,704	0	794,704	66.00
67.00	06700	OCCUPATIONAL THERAPY	309,666	0	309,666	0	309,666	67.00
68.00	06800	SPEECH PATHOLOGY	155,333	0	155,333	0	155,333	68.00
69.00	06900	ELECTROCARDIOLOGY	416,952		416,952	0	416,952	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	541,101		541,101	0	541,101	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,663,264		1,663,264	0	1,663,264	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,652,145		1,652,145	0	1,652,145	73.00
74.00	07400	RENAL DIALYSIS	35,622		35,622	0	35,622	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	224,391		224,391	0	224,391	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	407,930		407,930	0	407,930	88.00
88.01	08801	RURAL HEALTH CLINIC II	499,383		499,383	0	499,383	88.01
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,562,967		2,562,967	0	2,562,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	970,997		970,997		970,997	92.00
200.00		Subtotal (see instructions)	28,214,428	0	28,214,428	0	28,214,428	200.00
201.00		Less Observation Beds	970,997		970,997		970,997	201.00
202.00		Total (see instructions)	27,243,431	0	27,243,431	0	27,243,431	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 1:06 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,611,907		4,611,907			30.00
31.00	03100	INTENSIVE CARE UNIT	798,222		798,222			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,602,262	27,846,084	35,448,346	0.169183	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	3,736,392	13,340,517	17,076,909	0.021696	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,230,396	6,895,783	8,126,179	0.215550	0.000000	54.00
54.01	03630	ULTRA SOUND	301,782	2,696,091	2,997,873	0.097979	0.000000	54.01
56.00	05600	RADIOISOTOPE	176,487	2,177,761	2,354,248	0.172323	0.000000	56.00
57.00	05700	CT SCAN	4,857,250	25,314,961	30,172,211	0.019038	0.000000	57.00
58.00	05800	MRI	181,005	3,059,467	3,240,472	0.059550	0.000000	58.00
60.00	06000	LABORATORY	5,688,723	28,367,192	34,055,915	0.067848	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	365,638	166,354	531,992	0.253333	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,487,184	671,031	2,158,215	0.355168	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	682,559	2,643,429	3,325,988	0.238938	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	337,317	1,611,268	1,948,585	0.158918	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,726	270,711	295,437	0.525774	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,196,964	3,487,514	4,684,478	0.089007	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,094,886	197,461	1,292,347	0.418696	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,648,045	3,151,279	7,799,324	0.213257	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,374,428	4,135,743	7,510,171	0.219988	0.000000	73.00
74.00	07400	RENAL DIALYSIS	8,910	5,940	14,850	2.398788	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	710,640	710,640	0.315759	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	302,259	302,259			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	545,801	545,801			88.01
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	2,567,551	18,698,183	21,265,734	0.120521	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	328,688	987,551	1,316,239	0.737706	0.000000	92.00
200.00		Subtotal (see instructions)	45,301,322	147,283,020	192,584,342			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	45,301,322	147,283,020	192,584,342			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 1:06 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.169183	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	0.021696	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.215550	54.00
54.01	03630	ULTRA SOUND	0.097979	54.01
56.00	05600	RADIOISOTOPE	0.172323	56.00
57.00	05700	CT SCAN	0.019038	57.00
58.00	05800	MRI	0.059550	58.00
60.00	06000	LABORATORY	0.067848	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.253333	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.355168	65.00
66.00	06600	PHYSICAL THERAPY	0.238938	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.158918	67.00
68.00	06800	SPEECH PATHOLOGY	0.525774	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089007	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.418696	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.213257	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.219988	73.00
74.00	07400	RENAL DIALYSIS	2.398788	74.00
76.00	03020	ACUPUNCTURE	0.000000	76.00
76.01	03610	SLEEP LAB	0.315759	76.01
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.120521	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.737706	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 1:06 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,118,754		4,118,754	0	4,118,754	30.00
31.00	03100	INTENSIVE CARE UNIT	1,063,120		1,063,120	0	1,063,120	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,997,269		5,997,269	0	5,997,269	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	370,493		370,493	0	370,493	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,751,601		1,751,601	0	1,751,601	54.00
54.01	03630	ULTRA SOUND	293,730		293,730	0	293,730	54.01
56.00	05600	RADIOISOTOPE	405,692		405,692	0	405,692	56.00
57.00	05700	CT SCAN	574,406		574,406	0	574,406	57.00
58.00	05800	MRI	192,971		192,971	0	192,971	58.00
60.00	06000	LABORATORY	2,310,638		2,310,638	0	2,310,638	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	134,771		134,771	0	134,771	62.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	766,528	0	766,528	0	766,528	65.00
66.00	06600	PHYSICAL THERAPY	794,704	0	794,704	0	794,704	66.00
67.00	06700	OCCUPATIONAL THERAPY	309,666	0	309,666	0	309,666	67.00
68.00	06800	SPEECH PATHOLOGY	155,333	0	155,333	0	155,333	68.00
69.00	06900	ELECTROCARDIOLOGY	416,952		416,952	0	416,952	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	541,101		541,101	0	541,101	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,663,264		1,663,264	0	1,663,264	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,652,145		1,652,145	0	1,652,145	73.00
74.00	07400	RENAL DIALYSIS	35,622		35,622	0	35,622	74.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	224,391		224,391	0	224,391	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	407,930		407,930	0	407,930	88.00
88.01	08801	RURAL HEALTH CLINIC II	499,383		499,383	0	499,383	88.01
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,562,967		2,562,967	0	2,562,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	970,997		970,997		970,997	92.00
200.00		Subtotal (see instructions)	28,214,428	0	28,214,428	0	28,214,428	200.00
201.00		Less Observation Beds	970,997		970,997		970,997	201.00
202.00		Total (see instructions)	27,243,431	0	27,243,431	0	27,243,431	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 1:06 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,611,907		4,611,907			30.00
31.00	03100	INTENSIVE CARE UNIT	798,222		798,222			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,602,262	27,846,084	35,448,346	0.169183	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	3,736,392	13,340,517	17,076,909	0.021696	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,230,396	6,895,783	8,126,179	0.215550	0.000000	54.00
54.01	03630	ULTRA SOUND	301,782	2,696,091	2,997,873	0.097979	0.000000	54.01
56.00	05600	RADIOISOTOPE	176,487	2,177,761	2,354,248	0.172323	0.000000	56.00
57.00	05700	CT SCAN	4,857,250	25,314,961	30,172,211	0.019038	0.000000	57.00
58.00	05800	MRI	181,005	3,059,467	3,240,472	0.059550	0.000000	58.00
60.00	06000	LABORATORY	5,688,723	28,367,192	34,055,915	0.067848	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	365,638	166,354	531,992	0.253333	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,487,184	671,031	2,158,215	0.355168	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	682,559	2,643,429	3,325,988	0.238938	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	337,317	1,611,268	1,948,585	0.158918	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	24,726	270,711	295,437	0.525774	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,196,964	3,487,514	4,684,478	0.089007	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,094,886	197,461	1,292,347	0.418696	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,648,045	3,151,279	7,799,324	0.213257	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,374,428	4,135,743	7,510,171	0.219988	0.000000	73.00
74.00	07400	RENAL DIALYSIS	8,910	5,940	14,850	2.398788	0.000000	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	710,640	710,640	0.315759	0.000000	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	302,259	302,259	1.349604	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	545,801	545,801	0.914954	0.000000	88.01
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	2,567,551	18,698,183	21,265,734	0.120521	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	328,688	987,551	1,316,239	0.737706	0.000000	92.00
200.00		Subtotal (see instructions)	45,301,322	147,283,020	192,584,342			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	45,301,322	147,283,020	192,584,342			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/25/2016 1:06 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	03630	ULTRA SOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part I | Date/Time Prepared: 5/25/2016 1:06 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	981,751	0	981,751	3,860	254.34	30.00
31.00	INTENSIVE CARE UNIT	207,289		207,289	294	705.06	31.00
200.00	Total (lines 30-199)	1,189,040		1,189,040	4,154		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	1,700	432,378				30.00
31.00	INTENSIVE CARE UNIT	127	89,543				31.00
200.00	Total (lines 30-199)	1,827	521,921				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/25/2016 1:06 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	736,055	35,448,346	0.020764	3,499,853	72,671	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	20,607	17,076,909	0.001207	1,694,260	2,045	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	196,649	8,126,179	0.024199	713,140	17,257	54.00
54.01	03630	ULTRA SOUND	25,833	2,997,873	0.008617	164,280	1,416	54.01
56.00	05600	RADIOISOTOPE	23,302	2,354,248	0.009898	119,404	1,182	56.00
57.00	05700	CT SCAN	26,498	30,172,211	0.000878	2,709,372	2,379	57.00
58.00	05800	MRI	4,496	3,240,472	0.001387	129,956	180	58.00
60.00	06000	LABORATORY	180,965	34,055,915	0.005314	3,190,334	16,953	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	8,350	531,992	0.015696	206,904	3,248	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	70,821	2,158,215	0.032815	879,427	28,858	65.00
66.00	06600	PHYSICAL THERAPY	37,573	3,325,988	0.011297	430,015	4,858	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,022	1,948,585	0.003604	203,216	732	67.00
68.00	06800	SPEECH PATHOLOGY	3,042	295,437	0.010297	20,021	206	68.00
69.00	06900	ELECTROCARDIOLOGY	13,365	4,684,478	0.002853	764,426	2,181	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,093	1,292,347	0.014774	703,488	10,393	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	63,973	7,799,324	0.008202	2,409,428	19,762	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,665	7,510,171	0.009676	1,717,380	16,617	73.00
74.00	07400	RENAL DIALYSIS	9,073	14,850	0.610976	2,970	1,815	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	65,851	710,640	0.092664	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,699	302,259	0.025472	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	8,620	545,801	0.015793	0	0	88.01
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	305,979	21,265,734	0.014388	1,439,120	20,706	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	231,448	1,316,239	0.175840	148,182	26,056	92.00
200.00		Total (lines 50-199)	2,138,979	187,174,213		21,145,176	249,515	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part III Date/Time Prepared: 5/25/2016 1:06 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,860	0.00	1,700	0		30.00
31.00	03100	INTENSIVE CARE UNIT	294	0.00	127	0		31.00
200.00		Total (lines 30-199)	4,154		1,827	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/25/2016 1:06 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03630	ULTRA SOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/25/2016 1:06 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	35,448,346	0.000000	0.000000	3,499,853	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
53.00	05300	ANESTHESIOLOGY	0	17,076,909	0.000000	0.000000	1,694,260	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,126,179	0.000000	0.000000	713,140	54.00
54.01	03630	ULTRA SOUND	0	2,997,873	0.000000	0.000000	164,280	54.01
56.00	05600	RADIOISOTOPE	0	2,354,248	0.000000	0.000000	119,404	56.00
57.00	05700	CT SCAN	0	30,172,211	0.000000	0.000000	2,709,372	57.00
58.00	05800	MRI	0	3,240,472	0.000000	0.000000	129,956	58.00
60.00	06000	LABORATORY	0	34,055,915	0.000000	0.000000	3,190,334	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	531,992	0.000000	0.000000	206,904	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	2,158,215	0.000000	0.000000	879,427	65.00
66.00	06600	PHYSICAL THERAPY	0	3,325,988	0.000000	0.000000	430,015	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,948,585	0.000000	0.000000	203,216	67.00
68.00	06800	SPEECH PATHOLOGY	0	295,437	0.000000	0.000000	20,021	68.00
69.00	06900	ELECTROCARDIOLOGY	0	4,684,478	0.000000	0.000000	764,426	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,292,347	0.000000	0.000000	703,488	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	7,799,324	0.000000	0.000000	2,409,428	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,510,171	0.000000	0.000000	1,717,380	73.00
74.00	07400	RENAL DIALYSIS	0	14,850	0.000000	0.000000	2,970	74.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	710,640	0.000000	0.000000	0	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	302,259	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	545,801	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	21,265,734	0.000000	0.000000	1,439,120	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,316,239	0.000000	0.000000	148,182	92.00
200.00		Total (lines 50-199)	0	187,174,213			21,145,176	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/25/2016 1:06 pm

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		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	6,741,235	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	3,064,260	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,027,701	0		54.00
54.01	03630	ULTRA SOUND	0	1,012,507	0		54.01
56.00	05600	RADIOISOTOPE	0	820,209	0		56.00
57.00	05700	CT SCAN	0	7,793,337	0		57.00
58.00	05800	MRI	0	769,117	0		58.00
60.00	06000	LABORATORY	0	3,435,549	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	53,031	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	209,268	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,397,525	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	92,190	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	824,220	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,207,386	0		73.00
74.00	07400	RENAL DIALYSIS	0	5,940	0		74.00
76.00	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	0	223,020	0		76.01
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	4,168,996	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	300,974	0		92.00
200.00		Total (lines 50-199)	0	34,146,465	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/25/2016 1:06 pm

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		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	0.169183	6,741,235	0	0	1,140,502	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.021696	3,064,260	0	0	66,482	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.215550	2,027,701	0	0	437,071	54.00
54.01	03630	ULTRA SOUND	0.097979	1,012,507	0	0	99,204	54.01
56.00	05600	RADIOISOTOPE	0.172323	820,209	0	0	141,341	56.00
57.00	05700	CT SCAN	0.019038	7,793,337	0	0	148,370	57.00
58.00	05800	MRI	0.059550	769,117	0	0	45,801	58.00
60.00	06000	LABORATORY	0.067848	3,435,549	0	0	233,095	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.253333	53,031	0	0	13,435	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.355168	209,268	0	0	74,325	65.00
66.00	06600	PHYSICAL THERAPY	0.238938	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.158918	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.525774	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089007	1,397,525	0	0	124,390	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.418696	92,190	0	0	38,600	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.213257	824,220	0	0	175,771	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.219988	1,207,386	0	0	265,610	73.00
74.00	07400	RENAL DIALYSIS	2.398788	5,940	0	0	14,249	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.315759	223,020	0	0	70,421	76.01
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.120521	4,168,996	0	0	502,452	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.737706	300,974	0	0	222,030	92.00
200.00		Subtotal (see instructions)		34,146,465	0	0	3,813,149	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		34,146,465	0	0	3,813,149	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/25/2016 1:06 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
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03630	ULTRA SOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 1:06 pm

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	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)	3,860	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,860	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)	2,950	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,700	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,118,754	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,118,754	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,118,754	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)	1,067.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,813,951	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)	1,813,951	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 1:06 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	1,063,120	294	3,616.05	127	459,238	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)	3,149,471	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,422,660	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)	521,921	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	249,515	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	771,436	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,651,224	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)	910	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,067.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	970,997	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/25/2016 1:06 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	981,751	4,118,754	0.238361	970,997	231,448	90.00
91.00	Nursing School cost	0	4,118,754	0.000000	970,997	0	91.00
92.00	Allied health cost	0	4,118,754	0.000000	970,997	0	92.00
93.00	All other Medical Education	0	4,118,754	0.000000	970,997	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/25/2016 1:06 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		2,668,760		30.00
31.00	03100	INTENSIVE CARE UNIT		344,574		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.169183	3,499,853	592,116	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.021696	1,694,260	36,759	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.215550	713,140	153,717	54.00
54.01	03630	ULTRA SOUND	0.097979	164,280	16,096	54.01
56.00	05600	RADIOISOTOPE	0.172323	119,404	20,576	56.00
57.00	05700	CT SCAN	0.019038	2,709,372	51,581	57.00
58.00	05800	MRI	0.059550	129,956	7,739	58.00
60.00	06000	LABORATORY	0.067848	3,190,334	216,458	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.253333	206,904	52,416	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.355168	879,427	312,344	65.00
66.00	06600	PHYSICAL THERAPY	0.238938	430,015	102,747	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.158918	203,216	32,295	67.00
68.00	06800	SPEECH PATHOLOGY	0.525774	20,021	10,527	68.00
69.00	06900	ELECTROCARDIOLOGY	0.089007	764,426	68,039	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.418696	703,488	294,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.213257	2,409,428	513,827	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.219988	1,717,380	377,803	73.00
74.00	07400	RENAL DIALYSIS	2.398788	2,970	7,124	74.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.315759	0	0	76.01
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.120521	1,439,120	173,444	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.737706	148,182	109,315	92.00
200.00		Total (sum of lines 50-94 and 96-98)		21,145,176	3,149,471	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)		21,145,176		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/25/2016 1:06 pm

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		0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		2,513,961		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		921,785		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)		14,585		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		343,768		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		44.51		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	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0		29.01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		5.70		30.00
31.00	Percentage of Medicaid patient days (see instructions)		16.03		31.00
32.00	Sum of lines 30 and 31		21.73		32.00
33.00	Allowable disproportionate share percentage (see instructions)		7.14		33.00
34.00	Disproportionate share adjustment (see instructions)		61,328		34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A | Date/Time Prepared: 5/25/2016 1:06 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		7,647,644,885	6,406,145,534	35.00
35.01	Factor 3 (see instructions)		0.000019378	0.000019507	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		148,196	124,965	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		110,842	31,412	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		142,254		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		3,653,913		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		4,988,435		48.00
49.00	Total payment for inpatient operating costs (see instructions)		4,654,805		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		277,026		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)		4,931,831		59.00
60.00	Primary payer payments		3,446		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		4,928,385		61.00
62.00	Deductibles billed to program beneficiaries		528,980		62.00
63.00	Coinsurance billed to program beneficiaries		4,725		63.00
64.00	Allowable bad debts (see instructions)		177,630		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		115,460		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		166,670		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		4,510,140		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)		-2,936		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		-12,381		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-10,126		70.93
70.94	HRR adjustment amount (see instructions)		-42,360		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E Part A Date/Time Prepared: 5/25/2016 1:06 pm

Title XVIII | Hospital | PPS

			Prior to October 1	On/After October 1	
		0	1.00	2.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		4,442,337		71.00
71.01	Sequestration adjustment (see instructions)		88,847		71.01
72.00	Interim payments		4,350,816		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)		2,674		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		391,593		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	748,612	252,280	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.9972812993	0.9964291866	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	-2,035	-901	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.9870	0.9895	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	-9,732	-2,649	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140294	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/25/2016 1:06 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	3,813,149	2.00
3.00	PPS payments	3,113,770	3.00
4.00	Outlier payment (see instructions)	8,544	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)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	3,122,314	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)	678,846	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)	2,443,468	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,443,468	30.00
31.00	Primary payer payments	477	31.00
32.00	Subtotal (line 30 minus line 31)	2,442,991	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)	207,234	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	134,702	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	189,008	36.00
37.00	Subtotal (see instructions)	2,577,693	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,577,693	40.00
40.01	Sequestration adjustment (see instructions)	51,554	40.01
41.00	Interim payments	2,490,043	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	36,096	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2016 1:06 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		4,350,816		2,490,043	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)		4,350,816		2,490,043	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		2,674		36,096	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,353,490		2,526,139	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140294 | Component CCN: 14U294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/25/2016 1:06 pm

Title XVIII | Swing Beds - SNF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		0		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140294	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/25/2016 1:06 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	1,078	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,827	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	200	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	3,244	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	192,584,342	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	549,314	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)	313,300	8.00
9.00	Sequestration adjustment amount (see instructions)	6,266	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	307,034	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	320,468	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)	-13,434	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-2

Component CCN: 14U294 | Date/Time Prepared: 5/25/2016 1:06 pm

Title XVIII | Swing Beds - SNF | PPS

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	0	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for 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	0	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	0	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	0	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	0	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	0	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	0	0	19.00
19.01	Sequestration adjustment (see instructions)	0	0	19.01
20.00	Interim payments	0	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	0	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 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: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/25/2016 1:06 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	-209,496	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	-3,646,776	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-764,629	0	0	0	6.00
7.00	Inventory	2,179,869	0	0	0	7.00
8.00	Prepaid expenses	343,435	0	0	0	8.00
9.00	Other current assets	495,561	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	-1,602,036	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	961,157	0	0	0	12.00
13.00	Land improvements	411,367	0	0	0	13.00
14.00	Accumulated depreciation	-171,192	0	0	0	14.00
15.00	Buildings	28,745,221	0	0	0	15.00
16.00	Accumulated depreciation	-9,042,001	0	0	0	16.00
17.00	Leasehold improvements	5,765,232	0	0	0	17.00
18.00	Accumulated depreciation	-2,300,001	0	0	0	18.00
19.00	Fixed equipment	2,162,477	0	0	0	19.00
20.00	Accumulated depreciation	-931,783	0	0	0	20.00
21.00	Automobiles and trucks	28,013	0	0	0	21.00
22.00	Accumulated depreciation	-13,054	0	0	0	22.00
23.00	Major movable equipment	10,217,944	0	0	0	23.00
24.00	Accumulated depreciation	-7,428,912	0	0	0	24.00
25.00	Minor equipment depreciable	3,562,035	0	0	0	25.00
26.00	Accumulated depreciation	-2,432,863	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)	29,533,640	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	-2,505,484	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	-2,505,484	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	25,426,120	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,302,330	0	0	0	37.00
38.00	Salaries, wages, and fees payable	880,591	0	0	0	38.00
39.00	Payroll taxes payable	88,953	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	-79,294,087	0	0	0	43.00
44.00	Other current liabilities	118,774	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	-76,903,439	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	0	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	-76,903,439	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	102,329,559				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)	102,329,559	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	25,426,120	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/25/2016 1:06 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		93,448,470		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		8,881,089				2.00
3.00	Total (sum of line 1 and line 2)		102,329,559		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)		102,329,559		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)		102,329,559		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140294 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/25/2016 1:06 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,611,907		4,611,907	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4,611,907		4,611,907	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	798,222		798,222	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)	798,222		798,222	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,410,129		5,410,129	17.00
18.00	Ancillary services	36,994,954	126,749,226	163,744,180	18.00
19.00	Outpatient services	2,896,239	19,685,734	22,581,973	19.00
20.00	RURAL HEALTH CLINIC	0	302,259	302,259	20.00
20.01	RURAL HEALTH CLINIC II	0	545,801	545,801	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICE REVENUE	0	219,295	219,295	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	45,301,322	147,502,315	192,803,637	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,039,724		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)		36,039,724		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 140294	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 5/25/2016 1:06 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	192,803,637	1.00
2.00	Less contractual allowances and discounts on patients' accounts	148,345,915	2.00
3.00	Net patient revenues (line 1 minus line 2)	44,457,722	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	36,039,724	4.00
5.00	Net income from service to patients (line 3 minus line 4)	8,417,998	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER INCOME	463,091	24.00
25.00	Total other income (sum of lines 6-24)	463,091	25.00
26.00	Total (line 5 plus line 25)	8,881,089	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)	8,881,089	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140294	Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III Date/Time Prepared: 5/25/2016 1:06 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	270,765	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	6,261	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)	8.89	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)	277,026	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: 140294 Component CCN: 148524 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/25/2016 1:06 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	128,525	0	128,525	0	128,525	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	27,489	0	27,489	0	27,489	4.00
5.00	Other Nurse	0	0	0	0	0	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	6,589	6,589	0	6,589	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)	156,014	6,589	162,603	0	162,603	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	73	73	0	73	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	73	73	0	73	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	156,014	6,662	162,676	0	162,676	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	13,524	13,524	0	13,524	29.00
30.00	Administrative Costs	47,306	52,542	99,848	-4,347	95,501	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	47,306	66,066	113,372	-4,347	109,025	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	203,320	72,728	276,048	-4,347	271,701	32.00

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

Provider CCN: 140294 | Component CCN: 148524 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/25/2016 1:06 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	128,525		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	27,489		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	6,589		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	162,603		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	73		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	73		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	162,676		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	13,524		29.00
30.00	Administrative Costs	-4,411	91,090		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-4,411	104,614		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-4,411	267,290		32.00

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

Provider CCN: 140294 Component CCN: 148523 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/25/2016 1:06 pm

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	140,209	0	140,209	0	140,209	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	34,555	0	34,555	0	34,555	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	34,555	34,555	0	34,555	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)	174,764	34,555	209,319	0	209,319	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	1,674	1,674	0	1,674	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,674	1,674	0	1,674	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	174,764	36,229	210,993	0	210,993	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	36,815	36,815	0	36,815	29.00
30.00	Administrative Costs	27,271	82,393	109,664	-5,938	103,726	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	27,271	119,208	146,479	-5,938	140,541	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	202,035	155,437	357,472	-5,938	351,534	32.00

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

Provider CCN: 140294 | Component CCN: 148523 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/25/2016 1:06 pm

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	140,209		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	34,555		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	34,555		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	209,319		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	1,674		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,674		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	210,993		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	36,815		29.00
30.00	Administrative Costs	-8,369	95,357		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-8,369	132,172		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-8,369	343,165		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140294 | Component CCN: 148524 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-2 | Date/Time Prepared: 5/25/2016 1:06 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	0.73	4,380	4,200	3,066		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.73	4,380		3,066	4,380	4.00
5.00	Visiting Nurse	1.01	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.74	4,380			4,380	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)					162,676	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)					162,676	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)					104,614	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					140,640	15.00
16.00	Total overhead (sum of lines 14 and 15)					245,254	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					245,254	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					245,254	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					407,930	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140294 | Component CCN: 148523 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-2 | Date/Time Prepared: 5/25/2016 1:06 pm

Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	0	0		1.00
2.00	Physician Assistant	0.93	5,079	2,100	1,953		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.93	5,079		1,953	5,079	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)	0.93	5,079			5,079	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)					210,993	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)					210,993	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)					132,172	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					156,218	15.00
16.00	Total overhead (sum of lines 14 and 15)					288,390	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					288,390	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					288,390	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					499,383	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 140294 Component CCN: 148524	Period: From 01/01/2015 To 12/31/2015	Worksheet M-3 Date/Time Prepared: 5/25/2016 1:06 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)		407,930	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		6,931	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		400,999	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,380	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)		4,380	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		91.55	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)	80.44	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	91.55	91.55	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	943	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	86,332	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) *		86,332	16.00
16.01	Total program charges (see instructions)(from contractor's records)		150,913	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		16,651	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		9,525	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.)		54,450	16.04
16.05	Total program cost (see instructions)		63,975	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		8,744	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		25,104	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		63,975	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		6,931	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		70,906	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		70,906	26.00
26.01	Sequestration adjustment (see instructions)		1,418	26.01
27.00	Interim payments		94,731	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)		-25,243	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 140294 | Component CCN: 148523 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-3 | Date/Time Prepared: 5/25/2016 1:06 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		499,383	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		11,240	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		488,143	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,079	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)		5,079	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		96.11	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)	80.44	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	96.11	96.11	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,019	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	97,936	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) *		97,936	16.00
16.01	Total program charges (see instructions)(from contractor's records)		154,735	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		14,666	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		9,282	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.)		57,859	16.04
16.05	Total program cost (see instructions)		67,141	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		16,330	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		24,748	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		67,141	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,240	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		78,381	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		78,381	26.00
26.01	Sequestration adjustment (see instructions)		1,568	26.01
27.00	Interim payments		149,667	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)		-72,854	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 140294 | Component CCN: 148524 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-4 | Date/Time Prepared: 5/25/2016 1:06 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)	162,603	162,603	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.008188	0.008425	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,331	1,370	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	48	15	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,379	1,385	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	162,676	162,676	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	245,254	245,254	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.008477	0.008514	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,079	2,088	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,458	3,473	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	69	71	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	50.12	48.92	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	69	71	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,458	3,473	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)		6,931	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)		6,931	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 140294 | Component CCN: 148523 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-4 | Date/Time Prepared: 5/25/2016 1:06 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	209,319	209,319	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.009880	0.012506	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,068	2,618	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	48	15	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,116	2,633	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	210,993	210,993	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	288,390	288,390	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.010029	0.012479	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	2,892	3,599	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	5,008	6,232	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	79	100	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	63.39	62.32	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	79	100	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	5,008	6,232	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		11,240	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		11,240	16.00

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

Provider CCN: 140294 Component CCN: 148524 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-5 | Date/Time Prepared: 5/25/2016 1:06 pm

Rural Health Clinic (RHC) I | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		94,731	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		94,731	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		25,243	6.02
7.00	Total Medicare program liability (see instructions)		69,488	7.00

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

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

Provider CCN: 140294 Component CCN: 148523

Period: From 01/01/2015 To 12/31/2015

Worksheet M-5

Date/Time Prepared: 5/25/2016 1:06 pm

Rural Health Clinic (RHC) II

Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		149,667	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		149,667	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		72,854	6.02
7.00	Total Medicare program liability (see instructions)		76,813	7.00

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