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: 141301	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/27/2015 3:26 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/27/2015 Time: 3:26 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 KIRBY HOSPITAL (141301) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 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	-227,022	-98,261	93,049	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	-410,121	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		11,997		0	10.00
10.01	RURAL HEALTH CLINIC II	0		105,600		0	10.01
200.00	Total	0	-637,143	19,336	93,049	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: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/27/2015 3:23 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 MEDICAL CENTER DRIVE	PO Box:			1.00
2.00	City: MONTICELLO	State: IL	Zip Code: 61856	County: PIATT	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	KIRBY HOSPITAL	141301	16580	1	08/08/1999	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	KIRBY HOSPITAL - SWING BED	14Z301	16580		08/08/1999	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	ATWOOD RURAL HEALTH CLINIC	143438	16580		11/17/1997	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	KIRBY MEDICAL GROUP RHC	143495	16580		11/20/2008	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)	07/01/2014	06/30/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	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.	0	0	0	0	0	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/27/2015 3:23 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.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2015 3:23 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

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		1.00	2.00	3.00	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
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)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	38,942	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

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

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/27/2015 3:23 pm

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
					1.00	
	Multicampus					
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (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)						94,948	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)						0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2013	06/30/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 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: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/27/2015 3:23 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	11/03/2015	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/27/2015 3:23 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	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.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?	N		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	DANIEL	LARSEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	507-434-7055	DAN.LARSEN@CLACONNECT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/27/2015 3:23 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	11/03/2015			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.		PRINCIPAL		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: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/27/2015 3:23 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	16	5,840	16,368.00	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)		16	5,840	16,368.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		16	5,840	16,368.00	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)		16				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: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/27/2015 3:23 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)	400	18	682			1.00
2.00	HMO and other (see instructions)	206	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	629	0	1,285			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	328			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,029	18	2,295			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,029	18	2,295	0.00	158.48	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	522	0	4,279	0.00	5.62	26.00
26.01	RURAL HEALTH CLINIC II	2,634	0	14,363	0.00	22.57	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	186.67	27.00
28.00	Observation Bed Days		0	157			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: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/27/2015 3:23 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	129	7	226	1.00
2.00	HMO and other (see instructions)			70	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	129	7	226	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-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA

Provider CCN: 141301 Component CCN: 143438 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-8 Date/Time Prepared: 11/27/2015 3:23 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	108 SOUTH MAIN STREET	1.00
		City / State / ZIP Code	
		1.00 / 2.00 / 3.00	
2.00	City, State, ZIP Code, County	ATWOOD / IL / 61913	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			08:30	17:00	08:30	11.00

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

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

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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:30	17:00	08:30	17:00	11.00

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

Provider CCN: 141301
Component CCN: 143438

Period:
From 07/01/2014
To 06/30/2015

Worksheet S-8
Date/Time Prepared:
11/27/2015 3:23 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	08:30	16:00				11.00

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

Provider CCN: 141301 Component CCN: 143495 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-8 Date/Time Prepared: 11/27/2015 3:23 pm

		Rural Health Clinic (RHC) II	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1000 MEDICAL CENTER DRIVE	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	MONTICELLO	IL	61856	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			07:00	18:00	07:00	11.00

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

		Provider name	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		PIATT			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	18:00	07:00	18:00	07:00	18:00	11.00

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

Provider CCN: 141301
Component CCN: 143495

Period: From 07/01/2014 To 06/30/2015

Worksheet S-8
Date/Time Prepared: 11/27/2015 3:23 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	07:00	16:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 11/27/2015 3:23 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)	0.456883	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	6,708,033	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	7,140,705	6.00
7.00	Medicaid cost (line 1 times line 6)	3,262,467	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)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	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	774,114	996,876	1,770,990	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	353,680	455,456	809,136	21.00
22.00	Partial payment by patients approved for charity care	8,267	41,637	49,904	22.00
23.00	Cost of charity care (line 21 minus line 22)	345,413	413,819	759,232	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)	292,999	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	233,849	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	59,150	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	27,025	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	786,257	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	786,257	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/27/2015 3:23 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		3,515,511	3,515,511	62,314	3,577,825	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,469,147	1,469,147	24,761	1,493,908	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	129,188	129,188	0	129,188	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,260,621	3,134,305	5,394,926	152,652	5,547,578	5.00
6.00	00600	MAINTENANCE & REPAIRS	221,205	245,238	466,443	0	466,443	6.00
7.00	00700	OPERATION OF PLANT	0	377,359	377,359	0	377,359	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	73,602	73,602	8.00
9.00	00900	HOUSEKEEPING	270,188	108,846	379,034	-1,834	377,200	9.00
10.00	01000	DIETARY	258,982	214,212	473,194	-391,524	81,670	10.00
11.00	01100	CAFETERIA	0	0	0	389,899	389,899	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	95,668	12,182	107,850	0	107,850	14.00
15.00	01500	PHARMACY	54,931	223,464	278,395	0	278,395	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	483,168	246,620	729,788	0	729,788	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,230,953	666,012	1,896,965	-30,311	1,866,654	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	409,375	722,141	1,131,516	-9,004	1,122,512	50.00
53.00	05300	ANESTHESIOLOGY	107,823	13,882	121,705	0	121,705	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	632,818	873,429	1,506,247	-3,980	1,502,267	54.00
56.00	03630	ULTRA SOUND	0	20,315	20,315	0	20,315	56.00
60.00	06000	LABORATORY	530,106	1,091,031	1,621,137	-2,594	1,618,543	60.00
66.00	06600	PHYSICAL THERAPY	488,183	183,757	671,940	-3,980	667,960	66.00
67.00	06700	OCCUPATIONAL THERAPY	169,686	49,493	219,179	0	219,179	67.00
68.00	06800	SPEECH PATHOLOGY	0	14,446	14,446	0	14,446	68.00
69.00	06900	ELECTROCARDIOLOGY	17,920	3,269	21,189	13,651	34,840	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	84,251	84,251	0	84,251	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	71,208	71,208	0	71,208	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	257,341	257,341	0	257,341	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	335,406	162,567	497,973	-58,524	439,449	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,468,460	1,034,631	2,503,091	-185,183	2,317,908	88.01
91.00	09100	EMERGENCY	822,109	2,156,488	2,978,597	-29,002	2,949,595	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	297,155	179,393	476,548	-943	475,605	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,154,757	17,259,726	27,414,483	0	27,414,483	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
200.00		TOTAL (SUM OF LINES 118-199)	10,154,757	17,259,726	27,414,483	0	27,414,483	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/27/2015 3:23 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	-93,259	3,484,566		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-710,868	783,040		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	129,188		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-346,910	5,200,668		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	466,443		6.00
7.00	00700	OPERATION OF PLANT	7,929	385,288		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	73,602		8.00
9.00	00900	HOUSEKEEPING	0	377,200		9.00
10.00	01000	DIETARY	0	81,670		10.00
11.00	01100	CAFETERIA	-140,867	249,032		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	107,850		14.00
15.00	01500	PHARMACY	0	278,395		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-274	729,514		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-179,013	1,687,641		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-201,802	920,710		50.00
53.00	05300	ANESTHESIOLOGY	0	121,705		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-252,200	1,250,067		54.00
56.00	03630	ULTRA SOUND	0	20,315		56.00
60.00	06000	LABORATORY	0	1,618,543		60.00
66.00	06600	PHYSICAL THERAPY	-88,622	579,338		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	219,179		67.00
68.00	06800	SPEECH PATHOLOGY	0	14,446		68.00
69.00	06900	ELECTROCARDIOLOGY	-17,920	16,920		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	84,251		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	71,208		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	257,341		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	439,449		88.00
88.01	08801	RURAL HEALTH CLINIC II	-15,816	2,302,092		88.01
91.00	09100	EMERGENCY	-1,069,760	1,879,835		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-946	474,659		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,110,328	24,304,155		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,287	12,287		192.00
200.00		TOTAL (SUM OF LINES 118-199)	-3,098,041	24,316,442		200.00

RECLASSIFICATIONS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/27/2015 3:23 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - PROPERTY INSURANCE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	62,314	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	17,772	2.00
	0		0	80,086	
	B - CAPITAL LEASE INTEREST EXPENSE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	6,989	1.00
	0		0	6,989	
	D - CAFETERIA				
1.00	CAFETERIA	11.00	213,394	176,505	1.00
	0		213,394	176,505	
	E - EKG				
1.00	ELECTROCARDIOLOGY	69.00	10,717	2,934	1.00
2.00		0.00	0	0	2.00
	0		10,717	2,934	
	F - CASE MANAGEMENT				
1.00		0.00	0	0	1.00
	0		0	0	
	G - AMBULANCE				
1.00		0.00	0	0	1.00
	0		0	0	
	H - RHC ADMITTING				
1.00	ADMINISTRATIVE & GENERAL	5.00	194,611	45,116	1.00
2.00		0.00	0	0	2.00
	0		194,611	45,116	
	I - CHIEF MEDICAL OFFICER				
1.00		0.00	0	0	1.00
	0		0	0	
	J - LAUNDRY				
1.00	LAUNDRY & LINEN SERVICE	8.00	0	73,602	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
	0		0	73,602	
500.00	Grand Total: Increases		418,722	385,232	500.00

RECLASSIFICATIONS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/27/2015 3:23 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	A - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	80,086	12	1.00
2.00		0.00	0	0	12	2.00
	0		0	80,086		
	B - CAPITAL LEASE INTEREST EXPENSE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,989	11	1.00
	0		0	6,989		
	D - CAFETERIA					
1.00	DIETARY	10.00	213,394	176,505	0	1.00
	0		213,394	176,505		
	E - EKG					
1.00	LABORATORY	60.00	2,087	507	0	1.00
2.00	EMERGENCY	91.00	8,630	2,427	0	2.00
	0		10,717	2,934		
	F - CASE MANAGEMENT					
1.00		0.00	0	0	0	1.00
	0		0	0		
	G - AMBULANCE					
1.00		0.00	0	0	0	1.00
	0		0	0		
	H - RHC ADMITTING					
1.00	RURAL HEALTH CLINIC	88.00	47,510	11,014	0	1.00
2.00	RURAL HEALTH CLINIC II	88.01	147,101	34,102	0	2.00
	0		194,611	45,116		
	I - CHIEF MEDICAL OFFICER					
1.00		0.00	0	0	0	1.00
	0		0	0		
	J - LAUNDRY					
1.00	HOUSEKEEPING	9.00	0	1,834	0	1.00
2.00	DIETARY	10.00	0	1,625	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	30,311	0	3.00
4.00	OPERATING ROOM	50.00	0	9,004	0	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,980	0	5.00
6.00	PHYSICAL THERAPY	66.00	0	3,980	0	6.00
7.00	RURAL HEALTH CLINIC II	88.01	0	3,980	0	7.00
8.00	EMERGENCY	91.00	0	17,945	0	8.00
9.00	AMBULANCE SERVICES	95.00	0	943	0	9.00
	0		0	73,602		
500.00	Grand Total: Decreases		418,722	385,232		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 11/27/2015 3:23 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	349,650	0	0	0	0	1.00
2.00	Land Improvements	4,647,084	165,202	0	165,202	0	2.00
3.00	Buildings and Fixtures	15,952,577	225,384	0	225,384	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	10,003,358	327,864	0	327,864	0	5.00
6.00	Movable Equipment	5,558,073	732,706	0	732,706	157,318	6.00
7.00	HIT designated Assets	2,888,174	10,658	0	10,658	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,398,916	1,461,814	0	1,461,814	157,318	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	39,398,916	1,461,814	0	1,461,814	157,318	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	349,650	0	1.00
2.00	Land Improvements	4,812,286	0	2.00
3.00	Buildings and Fixtures	16,177,961	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	10,331,222	0	5.00
6.00	Movable Equipment	6,133,461	0	6.00
7.00	HIT designated Assets	2,898,832	0	7.00
8.00	Subtotal (sum of lines 1-7)	40,703,412	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	40,703,412	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 11/27/2015 3:23 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	3,515,511	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,469,147	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	4,984,658	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	3,515,511	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,469,147	2.00
3.00	Total (sum of lines 1-2)	0	4,984,658	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 11/27/2015 3:23 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	31,671,119	0	31,671,119	0.778095	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	9,032,293	0	9,032,293	0.221905	0	2.00
3.00	Total (sum of lines 1-2)	40,703,412	0	40,703,412	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,515,511	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	758,675	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	4,274,186	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-93,259	62,314	0	0	3,484,566	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,593	17,772	0	0	783,040	2.00
3.00	Total (sum of lines 1-2)	-86,666	80,086	0	0	4,267,606	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/27/2015 3:23 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-93,259	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-396	CAP REL COSTS-MVBLE EQUIP	2.00	11	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	-4,358	OPERATION OF PLANT	7.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,720,695			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-140,867	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	-274	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	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** 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

ADJUSTMENTS TO EXPENSES | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/27/2015 3:23 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	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-710,472	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS INCOME	B	-12,411	ADMINISTRATIVE & GENERAL	5.00	0	33.00
33.01	MISCELLANEOUS INCOME - AMBULANCE	B	-946	AMBULANCE SERVICES	95.00	0	33.01
33.02	CANCER CLINIC INCOME	B	-18,702	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	PHASE III CARDIAC REHAB INCOME	B	-88,622	PHYSICAL THERAPY	66.00	0	33.03
33.04	NON-ALLOWABLE ADVERTISING	A	-26,770	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	NON-ALLOWABLE LOBBYING	A	-8,099	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	PROPERTY TAX	A	-16,730	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	MEDICAID ASSESSMENT TAX	A	-256,506	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	KEY EMPLOYEE LIFE INSURANCE	A	-14,448	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	TRUST DEPR HOSPITAL ADMINISTRATION	A	6,756	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	TRUST DEPR OPERATION OF PLANT	A	12,287	OPERATION OF PLANT	7.00	0	33.10
33.11	TRUST DEPR PHYSICIAN PRIVATE OFFICES	A	12,287	PHYSICIANS' PRIVATE OFFICES	192.00	0	33.11
33.12	NON-ALLOWABLE PHYSICIAN RECRUITMENT	A	-15,816	RURAL HEALTH CLINIC II	88.01	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,098,041				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 11/27/2015 3:23 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	179,013	179,013	0	0	0	1.00
2.00	50.00	OPERATING ROOM	147,372	147,372	0	0	0	2.00
3.00	50.00	OPERATING ROOM	54,430	54,430	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	252,200	252,200	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	17,920	17,920	0	0	0	5.00
6.00	91.00	EMERGENCY	1,813,293	1,069,760	743,533	0	0	6.00
7.00	88.00	RURAL HEALTH CLINIC	157,382	0	157,382	0	0	7.00
8.00	88.01	RURAL HEALTH CLINIC II	599,190	0	599,190	0	0	8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	16,125	0	16,125	0	0	9.00
10.00	88.01	RURAL HEALTH CLINIC II	188,761	0	188,761	0	0	10.00
200.00			3,425,686	1,720,695	1,704,991		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	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	7.00
8.00	88.01	RURAL HEALTH CLINIC II	0	0	0	0	0	8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	9.00
10.00	88.01	RURAL HEALTH CLINIC II	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	179,013		1.00
2.00	50.00	OPERATING ROOM	0	0	0	147,372		2.00
3.00	50.00	OPERATING ROOM	0	0	0	54,430		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	252,200		4.00
5.00	69.00	ELECTROCARDIOLOGY	0	0	0	17,920		5.00
6.00	91.00	EMERGENCY	0	0	0	1,069,760		6.00
7.00	88.00	RURAL HEALTH CLINIC	0	0	0	0		7.00
8.00	88.01	RURAL HEALTH CLINIC II	0	0	0	0		8.00
9.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		9.00
10.00	88.01	RURAL HEALTH CLINIC II	0	0	0	0		10.00
200.00			0	0	0	1,720,695		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/27/2015 3:23 pm

Speech Pathology — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					42	1.00
2.00	Line 1 multiplied by 15 hours per week					630	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					82	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.63	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	222.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.80	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.90	34.90	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					15,496	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					15,496	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					15,496	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					69.80	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					43,974	22.00
23.00	Total salary equivalency (see instructions)					43,974	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					2,862	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					2,862	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					462	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,324	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					3,324	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/27/2015 3:23 pm

Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.80	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	43,974		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	3,324		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	47,298		63.00
64.00	Total cost of outside supplier services (from your records)	14,446		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	2,862		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	462		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	3,324		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	462		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	462		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/27/2015 3:23 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	3,484,566	3,484,566				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	783,040		783,040			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	129,188	0	0	129,188		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,200,668	244,965	69,649	31,235	5,546,517	5.00
6.00	00600	MAINTENANCE & REPAIRS	466,443	13,154	4,544	2,814	486,955	6.00
7.00	00700	OPERATION OF PLANT	385,288	700,060	60,363	0	1,145,711	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,602	15,396	0	0	88,998	8.00
9.00	00900	HOUSEKEEPING	377,200	57,928	656	3,437	439,221	9.00
10.00	01000	DIETARY	81,670	120,729	33,292	580	236,271	10.00
11.00	01100	CAFETERIA	249,032	57,295	0	2,715	309,042	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	107,850	61,582	1,907	1,217	172,556	14.00
15.00	01500	PHARMACY	278,395	51,984	0	699	331,078	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	729,514	76,686	13,711	6,147	826,058	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,687,641	464,888	59,125	15,660	2,227,314	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	920,710	392,880	72,357	5,208	1,391,155	50.00
53.00	05300	ANESTHESIOLOGY	121,705	0	0	1,372	123,077	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,250,067	175,149	321,631	8,051	1,754,898	54.00
56.00	03630	ULTRA SOUND	20,315	6,139	36,338	0	62,792	56.00
60.00	06000	LABORATORY	1,618,543	67,477	24,229	6,717	1,716,966	60.00
66.00	06600	PHYSICAL THERAPY	579,338	210,228	14,653	6,211	810,430	66.00
67.00	06700	OCCUPATIONAL THERAPY	219,179	0	0	2,159	221,338	67.00
68.00	06800	SPEECH PATHOLOGY	14,446	0	0	0	14,446	68.00
69.00	06900	ELECTROCARDIOLOGY	16,920	0	0	364	17,284	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	84,251	0	0	0	84,251	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	71,208	0	0	0	71,208	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	257,341	0	0	0	257,341	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	439,449	30,158	2,400	3,663	475,670	88.00
88.01	08801	RURAL HEALTH CLINIC II	2,302,092	373,635	17,688	16,810	2,710,225	88.01
91.00	09100	EMERGENCY	1,879,835	306,694	20,056	10,349	2,216,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	474,659	42,192	30,441	3,780	551,072	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,304,155	3,469,219	783,040	129,188	24,288,808	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,347	0	0	15,347	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,287	0	0	0	12,287	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,316,442	3,484,566	783,040	129,188	24,316,442	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/27/2015 3:23 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,546,517					5.00
6.00	00600	MAINTENANCE & REPAIRS	143,895	630,850				6.00
7.00	00700	OPERATION OF PLANT	338,558	136,878	1,621,147			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,299	3,010	9,998	128,305		8.00
9.00	00900	HOUSEKEEPING	129,790	11,326	37,621	2,906	620,864	9.00
10.00	01000	DIETARY	69,818	23,605	78,406	0	30,556	10.00
11.00	01100	CAFETERIA	91,322	11,203	37,210	0	14,501	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	50,990	12,041	39,994	0	15,586	14.00
15.00	01500	PHARMACY	97,834	10,164	33,761	0	13,157	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	244,100	14,994	49,803	0	19,409	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	658,171	90,897	301,915	54,190	117,663	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	411,086	76,818	255,151	16,098	99,437	50.00
53.00	05300	ANESTHESIOLOGY	36,369	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	518,572	34,246	113,749	7,115	44,330	54.00
56.00	03630	ULTRA SOUND	18,555	1,200	3,987	0	1,554	56.00
60.00	06000	LABORATORY	507,363	13,194	43,822	0	17,078	60.00
66.00	06600	PHYSICAL THERAPY	239,482	41,105	136,530	7,115	53,208	66.00
67.00	06700	OCCUPATIONAL THERAPY	65,405	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,269	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,107	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	24,896	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,042	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,044	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	140,560	5,897	0	0	7,633	88.00
88.01	08801	RURAL HEALTH CLINIC II	800,878	73,055	242,653	7,115	94,566	88.01
91.00	09100	EMERGENCY	655,104	59,966	199,179	32,081	77,623	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	162,842	8,250	27,401	1,685	10,679	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,538,351	627,849	1,611,180	128,305	616,980	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,535	3,001	9,967	0	3,884	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,631	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,546,517	630,850	1,621,147	128,305	620,864	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/27/2015 3:23 pm

		Cost Center Description	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	438,656					10.00
11.00	01100	CAFETERIA	0	463,278				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	11,153	302,320			14.00
15.00	01500	PHARMACY	0	4,059	471	490,524		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46,545	920	0	1,201,829	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	438,656	91,078	9,701	0	191,451	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	28,967	32,154	0	52,760	50.00
53.00	05300	ANESTHESIOLOGY	0	1,301	214	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	44,771	6,708	0	78,720	54.00
56.00	03630	ULTRA SOUND	0	0	1,530	0	14,542	56.00
60.00	06000	LABORATORY	0	38,505	100,783	0	228,828	60.00
66.00	06600	PHYSICAL THERAPY	0	26,642	1,713	0	31,728	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,922	0	0	1,202	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	601	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	115	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	18,433	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	15,580	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	56,304	490,524	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	8,492	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88,951	41,850	0	0	88.01
91.00	09100	EMERGENCY	0	37,362	5,931	0	531,570	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	36,022	1,421	0	70,427	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	438,656	463,278	302,320	490,524	1,201,829	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
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)	438,656	463,278	302,320	490,524	1,201,829	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/27/2015 3:23 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
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
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	4,181,036	0	4,181,036		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,363,626	0	2,363,626		50.00
53.00	05300	ANESTHESIOLOGY	160,961	0	160,961		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,603,109	0	2,603,109		54.00
56.00	03630	ULTRA SOUND	104,160	0	104,160		56.00
60.00	06000	LABORATORY	2,666,539	0	2,666,539		60.00
66.00	06600	PHYSICAL THERAPY	1,347,953	0	1,347,953		66.00
67.00	06700	OCCUPATIONAL THERAPY	295,867	0	295,867		67.00
68.00	06800	SPEECH PATHOLOGY	19,316	0	19,316		68.00
69.00	06900	ELECTROCARDIOLOGY	22,506	0	22,506		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	127,580	0	127,580		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	107,830	0	107,830		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	880,213	0	880,213		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	638,252	0	638,252		88.00
88.01	08801	RURAL HEALTH CLINIC II	4,059,293	0	4,059,293		88.01
91.00	09100	EMERGENCY	3,815,750	0	3,815,750		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	869,799	0	869,799		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,263,790	0	24,263,790		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	36,734	0	36,734		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,918	0	15,918		192.00
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)	24,316,442	0	24,316,442		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/27/2015 3:23 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	244,965	69,649	314,614	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	13,154	4,544	17,698	0	6.00
7.00	00700	OPERATION OF PLANT	0	700,060	60,363	760,423	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15,396	0	15,396	0	8.00
9.00	00900	HOUSEKEEPING	0	57,928	656	58,584	0	9.00
10.00	01000	DIETARY	0	120,729	33,292	154,021	0	10.00
11.00	01100	CAFETERIA	0	57,295	0	57,295	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	61,582	1,907	63,489	0	14.00
15.00	01500	PHARMACY	0	51,984	0	51,984	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	76,686	13,711	90,397	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	464,888	59,125	524,013	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	392,880	72,357	465,237	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	175,149	321,631	496,780	0	54.00
56.00	03630	ULTRA SOUND	0	6,139	36,338	42,477	0	56.00
60.00	06000	LABORATORY	0	67,477	24,229	91,706	0	60.00
66.00	06600	PHYSICAL THERAPY	0	210,228	14,653	224,881	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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	30,158	2,400	32,558	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	373,635	17,688	391,323	0	88.01
91.00	09100	EMERGENCY	0	306,694	20,056	326,750	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	42,192	30,441	72,633	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,469,219	783,040	4,252,259	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,347	0	15,347	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	3,484,566	783,040	4,267,606	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/27/2015 3:23 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	314,614					5.00
6.00	00600	MAINTENANCE & REPAIRS	8,162	25,860				6.00
7.00	00700	OPERATION OF PLANT	19,204	5,610	785,237			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,492	123	4,843	21,854		8.00
9.00	00900	HOUSEKEEPING	7,362	464	18,222	495	85,127	9.00
10.00	01000	DIETARY	3,960	968	37,978	0	4,190	10.00
11.00	01100	CAFETERIA	5,180	459	18,023	0	1,988	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,892	494	19,372	0	2,137	14.00
15.00	01500	PHARMACY	5,550	417	16,353	0	1,804	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,846	615	24,123	0	2,661	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,334	3,726	146,240	9,230	16,132	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,319	3,149	123,588	2,742	13,634	50.00
53.00	05300	ANESTHESIOLOGY	2,063	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,416	1,404	55,097	1,212	6,078	54.00
56.00	03630	ULTRA SOUND	1,053	49	1,931	0	213	56.00
60.00	06000	LABORATORY	28,780	541	21,226	0	2,342	60.00
66.00	06600	PHYSICAL THERAPY	13,584	1,685	66,131	1,212	7,295	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,710	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	242	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	290	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,412	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,194	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,314	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,973	242	0	0	1,047	88.00
88.01	08801	RURAL HEALTH CLINIC II	45,422	2,995	117,534	1,212	12,966	88.01
91.00	09100	EMERGENCY	37,160	2,458	96,476	5,464	10,643	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	9,237	338	13,272	287	1,464	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	314,151	25,737	780,409	21,854	84,594	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	257	123	4,828	0	533	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	206	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	314,614	25,860	785,237	21,854	85,127	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/27/2015 3:23 pm

		Cost Center Description	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	201,117					10.00
11.00	01100	CAFETERIA	0	82,945				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,997	90,381			14.00
15.00	01500	PHARMACY	0	727	141	76,976		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,333	275	0	140,250	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	201,117	16,307	2,900	0	22,342	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,186	9,613	0	6,157	50.00
53.00	05300	ANESTHESIOLOGY	0	233	64	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,016	2,006	0	9,186	54.00
56.00	03630	ULTRA SOUND	0	0	457	0	1,697	56.00
60.00	06000	LABORATORY	0	6,894	30,130	0	26,704	60.00
66.00	06600	PHYSICAL THERAPY	0	4,770	512	0	3,703	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,418	0	0	140	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	70	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	34	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	5,511	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	4,658	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	16,832	76,976	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	2,539	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	15,926	12,511	0	0	88.01
91.00	09100	EMERGENCY	0	6,689	1,773	0	62,032	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	6,449	425	0	8,219	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	201,117	82,945	90,381	76,976	140,250	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
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)	201,117	82,945	90,381	76,976	140,250	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/27/2015 3:23 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
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
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	979,341	0	979,341		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	652,625	0	652,625		50.00
53.00	05300	ANESTHESIOLOGY	2,360	0	2,360		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	609,195	0	609,195		54.00
56.00	03630	ULTRA SOUND	47,877	0	47,877		56.00
60.00	06000	LABORATORY	208,323	0	208,323		60.00
66.00	06600	PHYSICAL THERAPY	323,773	0	323,773		66.00
67.00	06700	OCCUPATIONAL THERAPY	5,268	0	5,268		67.00
68.00	06800	SPEECH PATHOLOGY	312	0	312		68.00
69.00	06900	ELECTROCARDIOLOGY	324	0	324		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,923	0	6,923		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,852	0	5,852		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	98,122	0	98,122		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	44,359	0	44,359		88.00
88.01	08801	RURAL HEALTH CLINIC II	599,889	0	599,889		88.01
91.00	09100	EMERGENCY	549,445	0	549,445		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	112,324	0	112,324		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,246,312	0	4,246,312		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,088	0	21,088		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	206	0	206		192.00
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)	4,267,606	0	4,267,606		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/27/2015 3:23 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	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	71,522					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		758,675				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,154,757			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,028	67,482	2,455,232	-5,546,517	18,769,925	5.00
6.00	00600	MAINTENANCE & REPAIRS	270	4,403	221,205	0	486,955	6.00
7.00	00700	OPERATION OF PLANT	14,369	58,485	0	0	1,145,711	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	316	0	0	0	88,998	8.00
9.00	00900	HOUSEKEEPING	1,189	636	270,188	0	439,221	9.00
10.00	01000	DIETARY	2,478	32,256	45,588	0	236,271	10.00
11.00	01100	CAFETERIA	1,176	0	213,394	0	309,042	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,264	1,848	95,668	0	172,556	14.00
15.00	01500	PHARMACY	1,067	0	54,931	0	331,078	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,574	13,284	483,168	0	826,058	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,542	57,285	1,230,953	0	2,227,314	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,064	70,106	409,375	0	1,391,155	50.00
53.00	05300	ANESTHESIOLOGY	0	0	107,823	0	123,077	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,595	311,622	632,818	0	1,754,898	54.00
56.00	03630	ULTRA SOUND	126	35,207	0	0	62,792	56.00
60.00	06000	LABORATORY	1,385	23,475	528,019	0	1,716,966	60.00
66.00	06600	PHYSICAL THERAPY	4,315	14,197	488,183	0	810,430	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	169,686	0	221,338	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	14,446	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	28,637	0	17,284	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	84,251	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	71,208	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	257,341	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	619	2,325	287,896	0	475,670	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,669	17,138	1,321,359	0	2,710,225	88.01
91.00	09100	EMERGENCY	6,295	19,432	813,479	0	2,216,934	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	866	29,494	297,155	0	551,072	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	71,207	758,675	10,154,757	-5,546,517	18,742,291	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	315	0	0	0	15,347	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	12,287	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,484,566	783,040	129,188		5,546,517	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	48.720198	1.032115	0.012722		0.295500	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		314,614	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.016762	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/27/2015 3:23 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	66,224					6.00
7.00	00700	OPERATION OF PLANT	14,369	51,236				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	316	316	83,451			8.00
9.00	00900	HOUSEKEEPING	1,189	1,189	1,890	50,350		9.00
10.00	01000	DIETARY	2,478	2,478	0	2,478	8,159	10.00
11.00	01100	CAFETERIA	1,176	1,176	0	1,176	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,264	1,264	0	1,264	0	14.00
15.00	01500	PHARMACY	1,067	1,067	0	1,067	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,574	1,574	0	1,574	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,542	9,542	35,245	9,542	8,159	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,064	8,064	10,470	8,064	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,595	3,595	4,628	3,595	0	54.00
56.00	03630	ULTRA SOUND	126	126	0	126	0	56.00
60.00	06000	LABORATORY	1,385	1,385	0	1,385	0	60.00
66.00	06600	PHYSICAL THERAPY	4,315	4,315	4,628	4,315	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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	619	0	0	619	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	7,669	7,669	4,628	7,669	0	88.01
91.00	09100	EMERGENCY	6,295	6,295	20,866	6,295	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	866	866	1,096	866	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	65,909	50,921	83,451	50,035	8,159	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	315	315	0	315	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	630,850	1,621,147	128,305	620,864	438,656	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.526003	31.640780	1.537489	12.330963	53.763451	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,860	785,237	21,854	85,127	201,117	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.390493	15.325884	0.261878	1.690705	24.649712	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/27/2015 3:23 pm

		Cost Center Description	CAFETERIA (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			11.00	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	11,755					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	283	1,381,784				14.00
15.00	01500	PHARMACY	103	2,152	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,181	4,203	0	10,000		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,311	44,339	0	1,593		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	735	146,965	0	439		50.00
53.00	05300	ANESTHESIOLOGY	33	977	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,136	30,661	0	655		54.00
56.00	03630	ULTRA SOUND	0	6,994	0	121		56.00
60.00	06000	LABORATORY	977	460,644	0	1,904		60.00
66.00	06600	PHYSICAL THERAPY	676	7,828	0	264		66.00
67.00	06700	OCCUPATIONAL THERAPY	201	0	0	10		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	5		68.00
69.00	06900	ELECTROCARDIOLOGY	0	525	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	84,251	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	71,208	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	257,341	100	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	38,813	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	2,257	191,280	0	0		88.01
91.00	09100	EMERGENCY	948	27,107	0	4,423		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	914	6,496	0	586		95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,755	1,381,784	100	10,000		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
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)	463,278	302,320	490,524	1,201,829		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	39.411144	0.218790	4,905.240000	120.182900		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	82,945	90,381	76,976	140,250		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.056146	0.065409	769.760000	14.025000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,181,036		4,181,036	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,363,626		2,363,626	0	0	50.00
53.00	05300	ANESTHESIOLOGY	160,961		160,961	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,603,109		2,603,109	0	0	54.00
56.00	03630	ULTRA SOUND	104,160		104,160	0	0	56.00
60.00	06000	LABORATORY	2,666,539		2,666,539	0	0	60.00
66.00	06600	PHYSICAL THERAPY	1,347,953	0	1,347,953	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	295,867	0	295,867	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	19,316	0	19,316	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	22,506		22,506	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	127,580		127,580	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	107,830		107,830	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	880,213		880,213	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	638,252		638,252	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	4,059,293		4,059,293	0	0	88.01
91.00	09100	EMERGENCY	3,815,750		3,815,750	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	305,787		305,787		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	869,799		869,799	0	0	95.00
200.00		Subtotal (see instructions)	24,569,577	0	24,569,577	0	0	200.00
201.00		Less Observation Beds	305,787		305,787		0	201.00
202.00		Total (see instructions)	24,263,790	0	24,263,790	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,834,427		3,834,427			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	129,213	5,642,885	5,772,098	0.409492	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	8,092	472,803	480,895	0.334711	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	167,514	8,043,174	8,210,688	0.317039	0.000000	54.00
56.00	03630	ULTRA SOUND	119,918	1,212,705	1,332,623	0.078162	0.000000	56.00
60.00	06000	LABORATORY	708,412	11,745,856	12,454,268	0.214106	0.000000	60.00
66.00	06600	PHYSICAL THERAPY	318,254	2,908,411	3,226,665	0.417754	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	171,305	94,844	266,149	1.111659	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	29,954	27,922	57,876	0.333748	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	14,354	525,521	539,875	0.041687	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	462,430	645,872	1,108,302	0.115113	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	140,667	140,667	0.766562	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,256,247	2,860,255	4,116,502	0.213825	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	687,352	687,352			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,623,989	2,623,989			88.01
91.00	09100	EMERGENCY	4,677	5,813,804	5,818,481	0.655798	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	522	241,632	242,154	1.262779	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	2,194,272	2,194,272	0.396395	0.000000	95.00
200.00		Subtotal (see instructions)	7,225,319	45,881,964	53,107,283			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,225,319	45,881,964	53,107,283			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I | Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	03630	ULTRA SOUND	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
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 PATIENTS	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
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC II			88.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	652,625	5,772,098	0.113065	52,078	5,888	50.00
53.00	05300	ANESTHESIOLOGY	2,360	480,895	0.004908	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	609,195	8,210,688	0.074195	81,746	6,065	54.00
56.00	03630	ULTRA SOUND	47,877	1,332,623	0.035927	67,599	2,429	56.00
60.00	06000	LABORATORY	208,323	12,454,268	0.016727	239,785	4,011	60.00
66.00	06600	PHYSICAL THERAPY	323,773	3,226,665	0.100343	28,121	2,822	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,268	266,149	0.019793	11,445	227	67.00
68.00	06800	SPEECH PATHOLOGY	312	57,876	0.005391	7,486	40	68.00
69.00	06900	ELECTROCARDIOLOGY	324	539,875	0.000600	7,112	4	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,923	1,108,302	0.006246	122,693	766	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,852	140,667	0.041602	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	98,122	4,116,502	0.023836	323,154	7,703	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	44,359	687,352	0.064536	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	599,889	2,623,989	0.228617	0	0	88.01
91.00	09100	EMERGENCY	549,445	5,818,481	0.094431	3,122	295	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	183,261	242,154	0.756795	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	3,337,908	47,078,584		944,341	30,250	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	03630	ULTRA SOUND	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
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 PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		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
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
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: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	5,772,098	0.000000	0.000000	52,078	50.00
53.00	05300	ANESTHESIOLOGY	0	480,895	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,210,688	0.000000	0.000000	81,746	54.00
56.00	03630	ULTRA SOUND	0	1,332,623	0.000000	0.000000	67,599	56.00
60.00	06000	LABORATORY	0	12,454,268	0.000000	0.000000	239,785	60.00
66.00	06600	PHYSICAL THERAPY	0	3,226,665	0.000000	0.000000	28,121	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	266,149	0.000000	0.000000	11,445	67.00
68.00	06800	SPEECH PATHOLOGY	0	57,876	0.000000	0.000000	7,486	68.00
69.00	06900	ELECTROCARDIOLOGY	0	539,875	0.000000	0.000000	7,112	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,108,302	0.000000	0.000000	122,693	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	140,667	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,116,502	0.000000	0.000000	323,154	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	687,352	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	2,623,989	0.000000	0.000000	0	88.01
91.00	09100	EMERGENCY	0	5,818,481	0.000000	0.000000	3,122	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	242,154	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	47,078,584			944,341	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	03630	ULTRA SOUND	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
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	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.409492	0	911,133	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.334711	0	60,697	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.317039	0	1,946,969	0	0	54.00
56.00	03630	ULTRA SOUND	0.078162	0	300,820	0	0	56.00
60.00	06000	LABORATORY	0.214106	0	2,818,562	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.417754	0	799,780	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.111659	0	17,664	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.333748	0	16,207	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.041687	0	148,784	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.115113	0	175,823	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.766562	0	1,753	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.213825	0	1,431,476	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	0.655798	0	1,326,938	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.262779	0	99,876	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.396395		0			95.00
200.00		Subtotal (see instructions)		0	10,056,482	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	10,056,482	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	373,102	0		50.00
53.00	05300	ANESTHESIOLOGY	20,316	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	617,265	0		54.00
56.00	03630	ULTRA SOUND	23,513	0		56.00
60.00	06000	LABORATORY	603,471	0		60.00
66.00	06600	PHYSICAL THERAPY	334,111	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	19,636	0		67.00
68.00	06800	SPEECH PATHOLOGY	5,409	0		68.00
69.00	06900	ELECTROCARDIOLOGY	6,202	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,240	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,344	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	306,085	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	870,203	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	126,121	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	3,327,018	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,327,018	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141301 | Component CCN: 14Z301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.409492	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.334711	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.317039	0	0	0	0	54.00
56.00	03630	ULTRA SOUND	0.078162	0	0	0	0	56.00
60.00	06000	LABORATORY	0.214106	0	0	0	0	60.00
66.00	06600	PHYSICAL THERAPY	0.417754	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.111659	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.333748	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.041687	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.115113	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.766562	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.213825	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	0.655798	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.262779	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.396395		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141301 | Component CCN: 14Z301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	03630	ULTRA SOUND	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
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 PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
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: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,452	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	839	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)	682	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)	1,285	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)	328	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	400	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)	629	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,181,036	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)	44,129	25.00
26.00	Total swing-bed cost (see instructions)	2,546,923	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,634,113	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)	1,634,113	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)	1,947.70	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	779,080	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)	779,080	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	216,400	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	995,480	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	1,225,103	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,225,103	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)	157	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,947.69	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	305,787	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	979,341	1,634,113	0.599310	305,787	183,261	90.00
91.00	Nursing School cost	0	1,634,113	0.000000	305,787	0	91.00
92.00	Allied health cost	0	1,634,113	0.000000	305,787	0	92.00
93.00	All other Medical Education	0	1,634,113	0.000000	305,787	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		869,006		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.409492	52,078	21,326	50.00
53.00	05300	ANESTHESIOLOGY	0.334711	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.317039	81,746	25,917	54.00
56.00	03630	ULTRA SOUND	0.078162	67,599	5,284	56.00
60.00	06000	LABORATORY	0.214106	239,785	51,339	60.00
66.00	06600	PHYSICAL THERAPY	0.417754	28,121	11,748	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.111659	11,445	12,723	67.00
68.00	06800	SPEECH PATHOLOGY	0.333748	7,486	2,498	68.00
69.00	06900	ELECTROCARDIOLOGY	0.041687	7,112	296	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.115113	122,693	14,124	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.766562	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.213825	323,154	69,098	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.655798	3,122	2,047	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.262779	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		944,341	216,400	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)		944,341		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141301 | Component CCN: 14Z301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.409492	27,491	11,257	50.00
53.00	05300	ANESTHESIOLOGY	0.334711	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.317039	26,124	8,282	54.00
56.00	03630	ULTRA SOUND	0.078162	8,388	656	56.00
60.00	06000	LABORATORY	0.214106	141,109	30,212	60.00
66.00	06600	PHYSICAL THERAPY	0.417754	139,439	58,251	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.111659	74,693	83,033	67.00
68.00	06800	SPEECH PATHOLOGY	0.333748	9,944	3,319	68.00
69.00	06900	ELECTROCARDIOLOGY	0.041687	1,016	42	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.115113	74,705	8,600	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.766562	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.213825	313,811	67,101	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	0.655798	1,249	819	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.262779	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		817,969	271,572	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)		817,969		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141301	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/27/2015 3:23 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,327,018	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,327,018	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)	3,360,288	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	20,853	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,444,392	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,895,043	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,895,043	30.00
31.00	Primary payer payments	2,425	31.00
32.00	Subtotal (line 30 minus line 31)	1,892,618	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)	278,440	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	211,614	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	2,104,232	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)	2,104,232	40.00
40.01	Sequestration adjustment (see instructions)	42,085	40.01
41.00	Interim payments	2,160,408	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-98,261	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: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		980,605		3,254,708	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	01/16/2015	117,400		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	01/23/2015	1,094,300	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)		117,400		-1,094,300	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,098,005		2,160,408	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		227,022		98,261	6.02
7.00	Total Medicare program liability (see instructions)		870,983		2,062,147	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: 141301 | Component CCN: 14Z301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/27/2015 3:23 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,698,417		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	01/16/2015	185,100		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)		185,100		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,883,517		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		410,121		0	6.02
7.00	Total Medicare program liability (see instructions)		1,473,396		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: 141301	Period: From 07/01/2014 To 06/30/2015	Worksheet E-1 Part II Date/Time Prepared: 11/27/2015 3:23 pm
	Title XVIII	Hospital	Cost

		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	226	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	400	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	206	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	682	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	53,107,283	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	1,770,990	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	94,948	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	94,948	8.00
9.00	Sequestration adjustment amount (see instructions)	1,899	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	93,049	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	93,049	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141301 Component CCN: 14Z301	Period: From 07/01/2014 To 06/30/2015	Worksheet E-2 Date/Time Prepared: 11/27/2015 3:23 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,237,354	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)	274,288	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	629	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,511,642	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,511,642	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,511,642	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	8,177	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,503,465	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,503,465	0	19.00
19.01	Sequestration adjustment (see instructions)	30,069	0	19.01
20.00	Interim payments	1,883,517	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)	-410,121	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141301	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part V Date/Time Prepared: 11/27/2015 3:23 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	995,480	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	995,480	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,005,435	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,005,435	19.00
20.00	Deductibles (exclude professional component)	123,800	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	881,635	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	881,635	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	9,373	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	7,123	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	888,758	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	888,758	30.00
30.01	Sequestration adjustment (see instructions)	17,775	30.01
31.00	Interim payments	1,098,005	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	-227,022	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/27/2015 3:23 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	3,875,295	0	0	0	1.00
2.00	Temporary investments	14,762,415	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,616,332	0	0	0	4.00
5.00	Other receivable	69,714	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-2,830,177	0	0	0	6.00
7.00	Inventory	207,812	0	0	0	7.00
8.00	Prepaid expenses	1,846,427	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	25,547,818	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	349,650	0	0	0	12.00
13.00	Land improvements	4,843,648	0	0	0	13.00
14.00	Accumulated depreciation	-1,053,594	0	0	0	14.00
15.00	Buildings	15,981,398	0	0	0	15.00
16.00	Accumulated depreciation	-3,448,633	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	10,331,222	0	0	0	19.00
20.00	Accumulated depreciation	-2,451,456	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,133,461	0	0	0	23.00
24.00	Accumulated depreciation	-3,367,070	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	2,898,832	0	0	0	27.00
28.00	Accumulated depreciation	-2,488,883	0	0	0	28.00
29.00	Minor equipment-nondepreciable	166,762	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	27,895,337	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	22,486,700	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	22,486,700	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	75,929,855	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	823,884	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,750,686	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	836,374	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	904,351	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,315,295	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	27,598,029	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	27,598,029	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	32,913,324	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	43,016,531				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)	43,016,531	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	75,929,855	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/27/2015 3:23 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		38,363,922		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,652,609				2.00
3.00	Total (sum of line 1 and line 2)		43,016,531		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)		43,016,531		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)		43,016,531		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: 141301 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/27/2015 3:23 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,108,706		4,108,706	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)	4,108,706		4,108,706	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4,108,706		4,108,706	17.00
18.00	Ancillary services	3,384,500	34,322,108	37,706,608	18.00
19.00	Outpatient services	4,371	6,056,263	6,060,634	19.00
20.00	RURAL HEALTH CLINIC	0	687,352	687,352	20.00
20.01	RURAL HEALTH CLINIC II	0	2,623,989	2,623,989	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	2,194,272	2,194,272	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	186,074	3,271,999	3,458,073	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,683,651	49,155,983	56,839,634	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,414,483		29.00
30.00	JEFFERSON PARKWAY OTHER EXPENSE	12,782			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)		12,782		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)		27,427,265		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141301	Period: From 07/01/2014 To 06/30/2015	Worksheet G-3 Date/Time Prepared: 11/27/2015 3:23 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	56,839,634	1.00
2.00	Less contractual allowances and discounts on patients' accounts	27,258,788	2.00
3.00	Net patient revenues (line 1 minus line 2)	29,580,846	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,427,265	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,153,581	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	585,402	6.00
7.00	Income from investments	-240,715	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	84,063	23.00
24.00	MISCELLANEOUS INCOME	615,942	24.00
24.01	OTHER DOCTOR BUILDING INCOME	32,384	24.01
24.02	EHR INCENTIVE REIMBURSEMENT	455,460	24.02
24.03	JEFFERSON PARKWAY	3,121	24.03
24.04	OTHER INSURANCE	415	24.04
24.05	TRUST HOSPITAL INCOME	950,174	24.05
25.00	Total other income (sum of lines 6-24)	2,486,246	25.00
26.00	Total (line 5 plus line 25)	4,639,827	26.00
27.00	JEFFERSON PARKWAY OTHER EXPENSE	-12,782	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	-12,782	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,652,609	29.00

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

Provider CCN: 141301 Component CCN: 143438 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/27/2015 3:23 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	44,386	0	44,386	0	44,386	1.00
2.00	Physician Assistant	51,509	0	51,509	0	51,509	2.00
3.00	Nurse Practitioner	57,337	0	57,337	0	57,337	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	134,665	0	134,665	0	134,665	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	4,150	4,150	0	4,150	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	287,897	4,150	292,047	0	292,047	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	61,646	61,646	0	61,646	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	1,195	1,195	0	1,195	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	62,841	62,841	0	62,841	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	287,897	66,991	354,888	0	354,888	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	13,913	13,913	0	13,913	29.00
30.00	Administrative Costs	47,510	81,662	129,172	-58,524	70,648	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	47,510	95,575	143,085	-58,524	84,561	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	335,407	162,566	497,973	-58,524	439,449	32.00

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

Provider CCN: 141301 | Component CCN: 143438 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/27/2015 3:23 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	44,386		1.00
2.00	Physician Assistant	0	51,509		2.00
3.00	Nurse Practitioner	0	57,337		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	134,665		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	4,150		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	292,047		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	61,646		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	1,195		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	62,841		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	354,888		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	13,913		29.00
30.00	Administrative Costs	0	70,648		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	84,561		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	439,449		32.00

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

Provider CCN: 141301 Component CCN: 143495 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/27/2015 3:23 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	549,557	0	549,557	0	549,557	1.00
2.00	Physician Assistant	174,575	0	174,575	0	174,575	2.00
3.00	Nurse Practitioner	63,819	0	63,819	0	63,819	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	355,357	0	355,357	0	355,357	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	67,575	67,575	0	67,575	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,143,308	67,575	1,210,883	0	1,210,883	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	299,850	299,850	0	299,850	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	299,850	299,850	0	299,850	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,143,308	367,425	1,510,733	0	1,510,733	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	11,987	11,987	0	11,987	29.00
30.00	Administrative Costs	325,152	655,219	980,371	-185,183	795,188	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	325,152	667,206	992,358	-185,183	807,175	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,468,460	1,034,631	2,503,091	-185,183	2,317,908	32.00

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

Provider CCN: 141301 | Component CCN: 143495 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/27/2015 3:23 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	549,557		1.00
2.00	Physician Assistant	0	174,575		2.00
3.00	Nurse Practitioner	0	63,819		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	355,357		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	67,575		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,210,883		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	299,850		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	299,850		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,510,733		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	11,987		29.00
30.00	Administrative Costs	-15,816	779,372		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-15,816	791,359		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-15,816	2,302,092		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141301 | Component CCN: 143438 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-2 | Date/Time Prepared: 11/27/2015 3:23 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	0.31	895	4,200	1,302		1.00
2.00	Physician Assistant	0.39	1,319	2,100	819		2.00
3.00	Nurse Practitioner	0.59	2,016	2,100	1,239		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.29	4,230		3,360	4,230	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	0.02	49			49	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)	1.31	4,279			4,279	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)					354,888	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)					354,888	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)					84,561	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					198,803	15.00
16.00	Total overhead (sum of lines 14 and 15)					283,364	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					283,364	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					283,364	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					638,252	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141301 | Component CCN: 143495 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-2 | Date/Time Prepared: 11/27/2015 3:23 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	2.05	7,550	4,200	8,610		1.00
2.00	Physician Assistant	1.50	4,153	2,100	3,150		2.00
3.00	Nurse Practitioner	0.70	1,356	2,100	1,470		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.25	13,059		13,230	13,230	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	0.26	724			724	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)	4.51	13,783			13,954	8.00
9.00	Physician Services Under Agreements		580			580	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)					1,510,733	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)					1,510,733	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)					791,359	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,757,201	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,548,560	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					2,548,560	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					2,548,560	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					4,059,293	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141301 | Component CCN: 143438 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-3 | Date/Time Prepared: 11/27/2015 3:23 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)		638,252	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		23,443	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		614,809	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,279	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)		4,279	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		143.68	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	143.68	143.68	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	522	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	75,001	0	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) *		75,001	16.00
16.01	Total program charges (see instructions)(from contractor's records)		87,045	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,902	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,639	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.)		52,546	16.04
16.05	Total program cost (see instructions)		54,185	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		7,680	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		15,493	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		54,185	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		7,243	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		61,428	22.00
23.00	Allowable bad debts (see instructions)		5,069	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		3,852	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		65,280	26.00
26.01	Sequestration adjustment (see instructions)		1,306	26.01
27.00	Interim payments		51,977	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)		11,997	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: 141301 | Component CCN: 143495 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-3 | Date/Time Prepared: 11/27/2015 3:23 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)		4,059,293	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		98,657	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		3,960,636	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		13,954	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		580	5.00
6.00	Total adjusted visits (line 4 plus line 5)		14,534	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		272.51	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	272.51	272.51	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	2,634	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	717,791	0	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) *		717,791	16.00
16.01	Total program charges (see instructions)(from contractor's records)		458,888	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		11,399	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		17,830	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.)		527,548	16.04
16.05	Total program cost (see instructions)		545,378	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		40,526	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		81,439	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		545,378	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		49,607	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		594,985	22.00
23.00	Allowable bad debts (see instructions)		14,816	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		11,260	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		606,245	26.00
26.01	Sequestration adjustment (see instructions)		12,125	26.01
27.00	Interim payments		488,520	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)		105,600	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: 141301 | Component CCN: 143438 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-4 | Date/Time Prepared: 11/27/2015 3:23 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)	292,047	292,047	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.003287	0.019313	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	960	5,640	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	4,001	2,434	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,961	8,074	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	354,888	354,888	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	283,364	283,364	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.013979	0.022751	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3,961	6,447	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	8,922	14,521	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	57	129	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	156.53	112.57	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	56	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	939	6,304	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)		23,443	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)		7,243	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141301 | Component CCN: 143495 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-4 | Date/Time Prepared: 11/27/2015 3:23 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)	1,210,883	1,210,883	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001728	0.010959	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,092	13,270	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	14,988	6,367	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	17,080	19,637	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,510,733	1,510,733	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	2,548,560	2,548,560	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.011306	0.012998	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	28,814	33,126	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	45,894	52,763	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	236	505	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	194.47	104.48	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	124	244	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	24,114	25,493	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)		98,657	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)		49,607	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141301 Component CCN: 143438	Period: From 07/01/2014 To 06/30/2015	Worksheet M-5 Date/Time Prepared: 11/27/2015 3:23 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		51,977	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)		51,977	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		11,997	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		63,974	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: 141301 Component CCN: 143495 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-5 | Date/Time Prepared: 11/27/2015 3:23 pm

Rural Health Clinic (RHC) II | Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		460,520	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		01/16/2015	28,000	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)		28,000	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		488,520	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		105,600	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		594,120	7.00

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