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: 141304	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/18/2015 7:12 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/18/2015 Time: 7:12 am
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 GENESIS MEDICAL CENTER - ALEDO (141304) 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)

VICE PRESIDENT FINANCE/CFO
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	84,855	-206,762	73,562	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	184,103	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-64,775		0	10.00
200.00	Total	0	268,958	-271,537	73,562	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: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/18/2015 7:12 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 409 N.W. NINTH AVENUE	PO Box:			1.00
2.00	City: ALEDO	State: IL	Zip Code: 61231-	County: MERCER	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	GENESIS MEDICAL CENTER - ALEDO	141304	19340	1	05/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	GENESIS MEDICAL CENTER - ALEDO, SWB	14Z304	19340		05/01/2000	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	GENESIS MEDICAL CENTER - ALEDO, RHC	143453	19340		02/29/2000	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 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.	0		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in 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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2015 7:12 am

		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.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2015 7:12 am

		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	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2015 7:12 am

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		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.	Y	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

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		V	XIX	
		1.00	2.00	
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.	Y	N	N	N	109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	12,949	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/18/2015 7:12 am

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	H55790	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: GENESIS HEALTH SYSTEM	Contractor's Name: WISCONSIN PHYSICIAN SERVICE HEALTH	Contractor's Number: 05001	141.00
142.00	Street: 1227 E RUSHOLME STREET	PO Box:		142.00
143.00	City: DAVENPORT	State: IA	Zip Code: 52803	143.00

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

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

		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)	75,063	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)	07/01/2014	09/30/2014	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: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/18/2015 7:12 am

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

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

		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	11/02/2015	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: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/18/2015 7:12 am

		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.				Y	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.				Y	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MARTY	ORWITZ	41.00
42.00	Enter the employer/company name of the cost report preparer.	GENESIS HEALTH SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-421-4175	ORWITZM@GENESISHEALTH.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/18/2015 7:12 am

		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)	11/02/2015			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.		DIRECTOR, REIMBURSEMENT		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: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/18/2015 7:12 am

	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	22	8,030	12,936.00	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)		22	8,030	12,936.00	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)		22	8,030	12,936.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		22				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: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/18/2015 7:12 am

	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)	343	26	527			1.00
2.00	HMO and other (see instructions)	91	21				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	870	0	1,148			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	59			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,213	26	1,734			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)	1,213	26	1,734	0.00	71.89	14.00
15.00	CAH visits	7,197	3,545	16,543			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	3,337	5,570	16,765	0.00	19.65	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	91.54	27.00
28.00	Observation Bed Days		22	194			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: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/18/2015 7:12 am

	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	103	8	169	1.00
2.00	HMO and other (see instructions)			21	7		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	103	8	169	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141304 Component CCN: 143453 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-8 | Date/Time Prepared: 11/18/2015 7:12 am

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			1007 NW 3RD STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	ALEDO		IL	61231	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
9.02				0		9.02
9.03				0		9.03
9.04				0		9.04
9.05				0		9.05
9.06				0		9.06
9.07				0		9.07
9.08				0		9.08
9.09				0		9.09
9.10				0		9.10
9.11				0		9.11
9.12				0		9.12
				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			06:30	19:30	07:30	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

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

Provider CCN: 141304
Component CCN: 143453

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

Worksheet S-8

Date/Time Prepared:
11/18/2015 7:12 am

Rural Health Clinic (RHC) I

Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		MERCER				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	17:30	07:30	17:30	07:30	17:30	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	06:30	19:30	07:30	13:30		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 11/18/2015 7:12 am

		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)	0.493364	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,355,114	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	4,154,090	6.00
7.00	Medicaid cost (line 1 times line 6)	2,049,478	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)	694,364	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)	694,364	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	313,348	0	313,348	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	154,595	0	154,595	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	154,595	0	154,595	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)	677,589	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	86,134	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	591,455	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	291,803	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	446,398	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,140,762	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/18/2015 7:12 am

		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	NEW CAP REL COSTS-BLDG & FIXT		0	0	400,894	400,894	1.00
1.01	00101	FOUNDATION BLDG		0	0	0	0	1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		619,637	619,637	-400,894	218,743	2.00
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	48,653	673,833	722,486	0	722,486	4.00
5.01	00570	ADMITTING	97,192	7,677	104,869	0	104,869	5.01
5.02	00590	HOSPITAL ONLY A & G	0	160,072	160,072	0	160,072	5.02
5.03	00591	SHARED ADMN & GENERAL	249,086	2,271,478	2,520,564	146,697	2,667,261	5.03
6.00	00600	MAINTENANCE & REPAIRS	131,252	450,245	581,497	0	581,497	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,898	3,365	26,263	0	26,263	8.00
9.00	00900	HOUSEKEEPING	42,348	109,399	151,747	0	151,747	9.00
10.00	01000	DIETARY	10,551	99,315	109,866	0	109,866	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	31,422	31,422	0	31,422	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	55,255	5,647	60,902	0	60,902	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	186,354	186,354	-994	185,360	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	751,744	237,881	989,625	-14,686	974,939	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	126,621	406,076	532,697	-315,376	217,321	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	395,053	300,932	695,985	-26,753	669,232	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	384,877	603,019	987,896	-2,520	985,376	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,520	2,520	63.00
65.00	06500	RESPIRATORY THERAPY	162,396	79,600	241,996	-17,419	224,577	65.00
66.00	06600	PHYSICAL THERAPY	285,375	91,147	376,522	-241	376,281	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	96,097	96,097	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	288,451	288,451	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	235,809	351,791	587,600	-128	587,472	73.00
76.00	03950	SLEEP LAB	19,365	2,376	21,741	-531	21,210	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,280,364	341,682	1,622,046	-147,082	1,474,964	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	637,214	1,161,459	1,798,673	-6,601	1,792,072	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	501	501	-501	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		245,220	245,220	0	245,220	113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,936,053	8,440,128	13,376,181	933	13,377,114	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	253,707	99,342	353,049	-933	352,116	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	0	0	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	4,103	4,103	0	4,103	194.04
200.00		TOTAL (SUM OF LINES 118-199)	5,189,760	8,543,573	13,733,333	0	13,733,333	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/18/2015 7:12 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	400,894		1.00
1.01	00101	FOUNDATION BLDG	0	0		1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-98,606	120,137		2.00
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	740	723,226		4.00
5.01	00570	ADMITTING	0	104,869		5.01
5.02	00590	HOSPITAL ONLY A & G	-3,592	156,480		5.02
5.03	00591	SHARED ADMN & GENERAL	-325,537	2,341,724		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	581,497		6.00
7.00	00700	OPERATION OF PLANT	0	0		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,263		8.00
9.00	00900	HOUSEKEEPING	0	151,747		9.00
10.00	01000	DIETARY	-26,504	83,362		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	96,781	96,781		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	48,244	79,666		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	146,145	146,145		16.00
17.00	01700	SOCIAL SERVICE	-5,250	55,652		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	185,360		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	974,939		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-12,960	204,361		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	669,232		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	-2,277	983,099		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,520		63.00
65.00	06500	RESPIRATORY THERAPY	-36,532	188,045		65.00
66.00	06600	PHYSICAL THERAPY	-777	375,504		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	96,097		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	288,451		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-20,134	567,338		73.00
76.00	03950	SLEEP LAB	0	21,210		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-53,496	1,421,468		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-129,692	1,662,380		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	INFUSION CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	-245,220	0		113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-668,667	12,708,447		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-178,390	173,726		192.00
194.00	07950	BOARD OF HEALTH	0	0		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0		194.01
194.02	07952	MOBILE MEALS	0	0		194.02
194.03	07953	KIDNEY CENTER	0	0		194.03
194.04	07955	RETAIL PHARMACY	0	4,103		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-847,057	12,886,276		200.00

RECLASSIFICATIONS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/18/2015 7:12 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	B - RHC SALARY					
1.00	SHARED ADMN & GENERAL	5.03	146,442	0		1.00
	TOTALS		146,442	0		
	C - BLOOD					
1.00	BLOOD STORING, PROCESSING & TRANS.	63.00	2,353	167		1.00
	TOTALS		2,353	167		
	D - MALPRACTICE INSURANCE					
1.00	SHARED ADMN & GENERAL	5.03	0	255		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	18		2.00
	TOTALS		0	273		
	E - MEDICAL SUPPLIES CHARGED TO PATIENTS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	384,548		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
	TOTALS		0	384,548		
	F - COST OF IMPLANTS					
1.00	IMPLANTABLE DEVICES CHARGED TO PATIE	72.00	0	288,451		1.00
	TOTALS		0	288,451		
	G - MISC AMBLNCE COSTS					
1.00	ADULTS & PEDIATRICS	30.00	0	501		1.00
	TOTALS		0	501		
	H - RECLASS DEPRECIATION EXPENSE					
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	400,894		1.00
	TOTALS		0	400,894		
500.00	Grand Total: Increases		148,795	1,074,834		500.00

RECLASSIFICATIONS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/18/2015 7:12 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - RHC SALARY						
1.00	RURAL HEALTH CLINIC	88.00	146,442	0	0		1.00
	TOTALS		146,442	0			
	C - BLOOD						
1.00	LABORATORY	60.00	2,353	167	0		1.00
	TOTALS		2,353	167			
	D - MALPRACTICE INSURANCE						
1.00	RURAL HEALTH CLINIC	88.00	0	273	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	273			
	E - MEDICAL SUPPLIES CHARGED TO PATIENTS						
1.00	ADULTS & PEDIATRICS	30.00	0	15,187	0		1.00
2.00	OPERATING ROOM	50.00	0	315,376	0		2.00
3.00	NONPHYSICIAN ANESTHETISTS	19.00	0	994	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	26,753	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	17,419	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	241	0		6.00
7.00	DRUGS CHARGED TO PATIENTS	73.00	0	128	0		7.00
8.00	SLEEP LAB	76.00	0	531	0		8.00
9.00	RURAL HEALTH CLINIC	88.00	0	367	0		9.00
10.00	EMERGENCY	91.00	0	6,601	0		10.00
11.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	951	0		11.00
	TOTALS		0	384,548			
	F - COST OF IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	288,451	0		1.00
	TOTALS		0	288,451			
	G - MISC AMBLNCE COSTS						
1.00	AMBULANCE SERVICES	95.00	0	501	0		1.00
	TOTALS		0	501			
	H - RECLASS DEPRECIATION EXPENSE						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	400,894	9		1.00
	TOTALS		0	400,894			
500.00	Grand Total: Decreases		148,795	1,074,834			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 11/18/2015 7:12 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	65,000	0	0	0	0	1.00
2.00	Land Improvements	8,829	223,299	0	223,299	0	2.00
3.00	Buildings and Fixtures	215,397	84,231	0	84,231	0	3.00
4.00	Building Improvements	8,478,516	3,007,495	0	3,007,495	0	4.00
5.00	Fixed Equipment	307,121	57,887	0	57,887	0	5.00
6.00	Movable Equipment	109,793	1,574,053	0	1,574,053	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	9,184,656	4,946,965	0	4,946,965	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	9,184,656	4,946,965	0	4,946,965	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	65,000	0	1.00
2.00	Land Improvements	232,128	0	2.00
3.00	Buildings and Fixtures	299,628	0	3.00
4.00	Building Improvements	11,486,011	0	4.00
5.00	Fixed Equipment	365,008	0	5.00
6.00	Movable Equipment	1,683,846	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,131,621	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	14,131,621	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II Date/Time Prepared: 11/18/2015 7:12 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	FOUNDATION BLDG	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	619,637	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	619,637	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	FOUNDATION BLDG	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	619,637	2.00
3.00	Total (sum of lines 1-2)	0	619,637	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 11/18/2015 7:12 am

	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	NEW CAP REL COSTS-BLDG & FIXT	12,447,775	0	12,447,775	0.880846	0	1.00
1.01	FOUNDATION BLDG	0	0	0	0.000000	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,683,846	0	1,683,846	0.119154	0	2.00
3.00	Total (sum of lines 1-2)	14,131,621	0	14,131,621	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	400,894	0	1.00
1.01	FOUNDATION BLDG	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	139,373	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	540,267	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	400,894	1.00
1.01	FOUNDATION BLDG	0	0	0	0	0	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-19,236	0	0	0	120,137	2.00
3.00	Total (sum of lines 1-2)	-19,236	0	0	0	521,031	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/18/2015 7:12 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - FOUNDATION BLDG (chapter 2)		0	FOUNDATION BLDG	1.01	0	1.01
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,219	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-229,191			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	-102,145			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-24,482	DIETARY	10.00	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		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - FOUNDATION BLDG		0	FOUNDATION BLDG	1.01	0	26.01
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/18/2015 7:12 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-76,151	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00			0		0.00	0	33.00
34.00	OTHER REVENUE - VENDOR REBATES	B	-2,120	LABORATORY	60.00	0	34.00
35.00	OTHER REVENUE - MISCELLANEOUS REVENU	B	-85	PHYSICAL THERAPY	66.00	0	35.00
36.00			0		0.00	0	36.00
37.00	REVENUE OFFSET	B	-40	DIETARY	10.00	0	37.00
38.00	REVENUE OFFSET	B	-4,329	SHARED ADMN & GENERAL	5.03	0	38.00
39.00	REVENUE OFFSET	B	-1,982	DIETARY	10.00	0	39.00
40.00	REVENUE OFFSET	B	-863	DRUGS CHARGED TO PATIENTS	73.00	0	40.00
41.00	REVENUE OFFSET	B	-8,550	SHARED ADMN & GENERAL	5.03	0	41.00
42.00	REVENUE OFFSET	B	-60	RURAL HEALTH CLINIC	88.00	0	42.00
43.00	REVENUE OFFSET	B	-20	RURAL HEALTH CLINIC	88.00	0	43.00
44.00	REVENUE OFFSET	B	-160	RURAL HEALTH CLINIC	88.00	0	44.00
45.00	REVENUE OFFSET	B	-1,060	RURAL HEALTH CLINIC	88.00	9	45.00
45.01	REVENUE OFFSET	B	-20	RURAL HEALTH CLINIC	88.00	0	45.01
45.02	REVENUE OFFSET	B	-40	RURAL HEALTH CLINIC	88.00	0	45.02
45.03	REVENUE OFFSET	B	-126	LABORATORY	60.00	0	45.03
45.04	REVENUE OFFSET	B	-338	EMERGENCY	91.00	0	45.04
45.05	REVENUE OFFSET	B	-5,250	SOCIAL SERVICE	17.00	0	45.05
45.06	REVENUE OFFSET	B	-14,700	DRUGS CHARGED TO PATIENTS	73.00	0	45.06
45.07	REVENUE OFFSET	B	-164	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.07
45.08	REVENUE OFFSET	B	-5,124	SHARED ADMN & GENERAL	5.03	0	45.08
45.09	REVENUE OFFSET	B	-4,807	SHARED ADMN & GENERAL	5.03	0	45.09
45.10	REVENUE OFFSET	B	-4,571	DRUGS CHARGED TO PATIENTS	73.00	0	45.10
45.11	REVENUE OFFSET	B	-2,250	SHARED ADMN & GENERAL	5.03	0	45.11
45.12	LOBBY DUES OFFSET	A	-8,021	SHARED ADMN & GENERAL	5.03	0	45.12
45.13	PATIENT PHONES SALARY	A	-937	SHARED ADMN & GENERAL	5.03	0	45.13
45.14	PATIENT PHONES BENEFITS	A	-122	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.14
45.15	PATIENT PHONES COST	A	-1,831	SHARED ADMN & GENERAL	5.03	0	45.15
45.16	ADVERTISING	A	-9,825	SHARED ADMN & GENERAL	5.03	0	45.16
45.17	ADVERTISING	A	-31	LABORATORY	60.00	0	45.17
45.18	ADVERTISING	A	-692	PHYSICAL THERAPY	66.00	0	45.18
45.19	ADVERTISING	A	-1,791	RURAL HEALTH CLINIC	88.00	0	45.19
45.20	ADVERTISING	A	-204	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.20
45.21	OCCUPATIONAL HEALTH	A	-34	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.21
45.22	PROVIDER TAX ASSESSMENT	A	-134,300	SHARED ADMN & GENERAL	5.03	0	45.22
45.23	PROFESSIONAL FEES OFFSET 100% PART B	A	-178,186	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.23
45.24	CAP INT EXP AMORTZ. RELATED PARTY	A	-19,236	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	45.24
45.25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.25
45.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.26
45.27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.27
45.28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.28
45.29	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.29
45.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	45.30
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-847,057				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 11/18/2015 7:12 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE EQUIP CAPITAL	16,416	0	1.00
2.00	5.03	SHARED ADMN & GENERAL	HOME OFFICE EQUIP CAPITAL	268,466	0	2.00
3.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOCR	1,060	0	3.00
4.00	5.02	HOSPITAL ONLY A & G	SBS PATIENT ACCOUNTING	156,317	159,909	4.00
4.01	5.03	SHARED ADMN & GENERAL	INFORMATION TECHNOLOGY	187,402	641,106	4.01
4.02	5.03	SHARED ADMN & GENERAL	HOME OFFICE POOLED	747,128	1,128,952	4.02
4.03	5.03	SHARED ADMN & GENERAL	HOME OFFICE ADMIN COSTS	26,697	0	4.03
4.04	0.00		0	0	0	4.04
4.06	5.03	SHARED ADMN & GENERAL	SBS PATIENT ACCESS	136,557	0	4.06
4.10	16.00	MEDICAL RECORDS & LIBRARY	TRANSCRIPTION	146,145	0	4.10
4.11	14.00	CENTRAL SERVICES & SUPPLY	CENTRAL SUPPLY	48,244	0	4.11
4.12	5.03	SHARED ADMN & GENERAL	MEDICAL AFFAIRS	23,084	0	4.12
4.13	5.03	SHARED ADMN & GENERAL	PAYOR CONTRACTING	8,084	0	4.13
4.14	13.00	NURSING ADMINISTRATION	CARE COORDINATION	96,781	0	4.14
4.15	5.03	SHARED ADMN & GENERAL	HOME OFFICE ADMIN COSTS	6,578	0	4.15
4.16	5.03	SHARED ADMN & GENERAL	LIBRARY	5,358	0	4.16
4.17	5.03	SHARED ADMN & GENERAL	AFFILIATE FACILITIES	198,725	0	4.17
4.18	5.03	SHARED ADMN & GENERAL	VARIOUS SERVICES - RELATED	705	705	4.18
4.19	6.00	MAINTENANCE & REPAIRS	VARIOUS SERVICES - RELATED	13,023	13,023	4.19
4.20	9.00	HOUSEKEEPING	VARIOUS SERVICES - RELATED	1,230	1,230	4.20
4.21	10.00	DIETARY	VARIOUS SERVICES - RELATED	27,090	27,090	4.21
4.22	30.00	ADULTS & PEDIATRICS	VARIOUS SERVICES - RELATED	19,559	19,559	4.22
4.24	50.00	OPERATING ROOM	VARIOUS SERVICES - RELATED	2,486	2,486	4.24
4.25	50.00	OPERATING ROOM	VARIOUS SERVICES - RELATED	994	994	4.25
4.26	54.00	RADIOLOGY-DIAGNOSTIC	VARIOUS SERVICES - RELATED	3,375	3,375	4.26
4.27	60.00	LABORATORY	VARIOUS SERVICES - RELATED	4,846	4,846	4.27
4.28	65.00	RESPIRATORY THERAPY	VARIOUS SERVICES - RELATED	16,120	16,120	4.28
4.29	66.00	PHYSICAL THERAPY	VARIOUS SERVICES - RELATED	1,440	1,440	4.29
4.30	73.00	DRUGS CHARGED TO PATIENTS	VARIOUS SERVICES - RELATED	21,326	21,326	4.30
4.31	88.00	RURAL HEALTH CLINIC	VARIOUS SERVICES - RELATED	1,394	1,394	4.31
4.32	91.00	EMERGENCY	VARIOUS SERVICES - RELATED	7,698	7,698	4.32
4.33	192.00	PHYSICIANS' PRIVATE OFFICES	VARIOUS SERVICES - RELATED	199	199	4.33
4.34	113.00	INTEREST EXPENSE	INTEREST EXPENSE RELATED	0	245,220	4.34
4.35	0.00			0	0	4.35
4.36	0.00			0	0	4.36
4.37	0.00			0	0	4.37
4.38	0.00			0	0	4.38
4.39	0.00			0	0	4.39
4.40	0.00			0	0	4.40
4.41	0.00			0	0	4.41
4.42	0.00			0	0	4.42
4.43	0.00			0	0	4.43
4.44	0.00			0	0	4.44
4.45	0.00			0	0	4.45
4.46	0.00			0	0	4.46
4.47	0.00			0	0	4.47
4.48	0.00			0	0	4.48
4.49	0.00			0	0	4.49
4.50	0.00			0	0	4.50
5.00	0		0	2,194,527	2,296,672	5.00

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

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

6.00	A	GMC ALEDO	100.00	GENESIS HLTH SY	100.00	6.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-1 | Date/Time Prepared: 11/18/2015 7:12 am

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141304	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8-1 Date/Time Prepared: 11/18/2015 7:12 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	16,416	0		1.00
2.00	268,466	0		2.00
3.00	1,060	0		3.00
4.00	-3,592	0		4.00
4.01	-453,704	0		4.01
4.02	-381,824	0		4.02
4.03	26,697	0		4.03
4.04	0	0		4.04
4.06	136,557	0		4.06
4.10	146,145	0		4.10
4.11	48,244	0		4.11
4.12	23,084	0		4.12
4.13	8,084	0		4.13
4.14	96,781	0		4.14
4.15	6,578	0		4.15
4.16	5,358	0		4.16
4.17	198,725	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.24	0	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
4.27	0	0		4.27
4.28	0	0		4.28
4.29	0	0		4.29
4.30	0	0		4.30
4.31	0	0		4.31
4.32	0	0		4.32
4.33	0	0		4.33
4.34	-245,220	0		4.34
4.35	0	0		4.35
4.36	0	0		4.36
4.37	0	0		4.37
4.38	0	0		4.38
4.39	0	0		4.39
4.40	0	0		4.40
4.41	0	0		4.41
4.42	0	0		4.42
4.43	0	0		4.43
4.44	0	0		4.44
4.45	0	0		4.45
4.46	0	0		4.46
4.47	0	0		4.47
4.48	0	0		4.48
4.49	0	0		4.49
4.50	0	0		4.50
5.00	-102,145	0		5.00

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

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

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

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

6.00	NOT-FOR PROFIT		6.00

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141304	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8-1 Date/Time Prepared: 11/18/2015 7:12 am

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 11/18/2015 7:12 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	AGGREGATE-EMERGENCY	983,485	129,354	854,131	0	0	1.00
2.00	88.00	AGGREGATE-RURAL HEALTH CLINIC	886,415	50,345	836,070	0	0	2.00
3.00	65.00	AGGREGATE-RESPIRATORY THERAPY	36,532	36,532	0	0	0	3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	12,960	12,960	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,919,392	229,191	1,690,201		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	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	1.00
2.00	88.00	AGGREGATE-RURAL HEALTH CLINIC	0	0	0	0	0	2.00
3.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	0	0	3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			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	91.00	AGGREGATE-EMERGENCY	0	0	0	129,354		1.00
2.00	88.00	AGGREGATE-RURAL HEALTH CLINIC	0	0	0	50,345		2.00
3.00	65.00	AGGREGATE-RESPIRATORY THERAPY	0	0	0	36,532		3.00
4.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	12,960		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	229,191		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/18/2015 7:12 am

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					51	1.00
2.00	Line 1 multiplied by 15 hours per week					765	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					242	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					5.50	7.00
8.00	Optional travel expense rate per mile					0.55	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,453.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.10	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)	36.55	36.55	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)					106,214	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)					106,214	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)					106,214	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)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					106,214	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)					8,845	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)					8,845	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)					1,331	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10,176	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)					10,176	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: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/18/2015 7:12 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		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)	73.10	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)	106,214		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	10,176		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)	116,390		63.00
64.00	Total cost of outside supplier services (from your records)	50,028		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	8,845		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,331		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	10,176		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	1,331		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	1,331		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: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/18/2015 7:12 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	FOUNDATION BLDG	NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	400,894	400,894				1.00
1.01	00101	FOUNDATION BLDG	0	0	0			1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	120,137			120,137		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	723,226	0	0	0	723,226	4.00
5.01	00570	ADMITTING	104,869	0	0	0	13,672	5.01
5.02	00590	HOSPITAL ONLY A & G	156,480	471	0	0	0	5.02
5.03	00591	SHARED ADMN & GENERAL	2,341,724	81,169	0	13,015	55,641	5.03
6.00	00600	MAINTENANCE & REPAIRS	581,497	36,837	0	22,006	18,464	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	26,263	1,092	0	0	3,221	8.00
9.00	00900	HOUSEKEEPING	151,747	5,277	0	0	5,957	9.00
10.00	01000	DIETARY	83,362	16,704	0	2,931	1,484	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	96,781	849	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	79,666	14,074	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	146,145	1,832	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	55,652	1,260	0	0	7,773	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	185,360	471	0	4,060	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	974,939	77,908	0	7,152	105,752	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	204,361	42,534	0	8,623	17,812	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	669,232	36,593	0	55,579	55,574	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	983,099	14,234	0	831	53,812	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,520	0	0	0	331	63.00
65.00	06500	RESPIRATORY THERAPY	188,045	2,672	0	0	22,845	65.00
66.00	06600	PHYSICAL THERAPY	375,504	19,956	0	0	40,145	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	96,097	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	288,451	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	567,338	4,974	0	1,640	33,172	73.00
76.00	03950	SLEEP LAB	21,210	7,100	0	0	2,724	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,421,468	0	0	0	159,517	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,662,380	19,931	0	4,300	89,640	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,708,447	385,938	0	120,137	687,536	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,756	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	173,726	0	0	0	35,690	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	13,200	0	0	0	194.03
194.04	07955	RETAIL PHARMACY	4,103	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,886,276	400,894	0	120,137	723,226	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/18/2015 7:12 am

		Cost Center Description	ADMITTING	Subtotal	HOSPITAL ONLY A & G	Subtotal	SHARED ADMN & GENERAL	
			5.01	5A.01	5.02	5A.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING	118,541					5.01
5.02	00590	HOSPITAL ONLY A & G	0	156,951	156,951			5.02
5.03	00591	SHARED ADMN & GENERAL	0	2,491,549	35,810	2,527,359	2,527,359	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	658,804	9,469	668,273	163,252	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	30,576	439	31,015	7,577	8.00
9.00	00900	HOUSEKEEPING	0	162,981	2,343	165,324	40,387	9.00
10.00	01000	DIETARY	0	104,481	1,502	105,983	25,891	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	97,630	1,403	99,033	24,193	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	93,740	1,347	95,087	23,229	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	147,977	2,127	150,104	36,669	16.00
17.00	01700	SOCIAL SERVICE	0	64,685	930	65,615	16,029	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	189,891	2,729	192,620	47,055	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,294	1,175,045	16,889	1,191,934	291,178	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,804	282,134	4,055	286,189	69,913	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,480	843,458	12,123	855,581	209,010	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	25,410	1,077,386	15,485	1,092,871	266,977	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	249	3,100	45	3,145	768	63.00
65.00	06500	RESPIRATORY THERAPY	2,893	216,455	3,111	219,566	53,638	65.00
66.00	06600	PHYSICAL THERAPY	6,084	441,689	6,348	448,037	109,451	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	2,044	98,141	1,411	99,552	24,320	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	5,037	293,488	4,218	297,706	72,727	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,085	621,209	8,929	630,138	153,936	73.00
76.00	03950	SLEEP LAB	1,146	32,180	463	32,643	7,974	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,580,985	0	1,580,985	386,219	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	17,015	1,793,266	25,775	1,819,041	444,377	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		0		92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118,541	12,657,801	156,951	12,657,801	2,474,770	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,756	0	1,756	429	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	209,416	0	209,416	51,158	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	13,200	0	13,200	0	194.03
194.04	07955	RETAIL PHARMACY	0	4,103	0	4,103	1,002	194.04
200.00		Cross Foot Adjustments		0		0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	118,541	12,886,276	156,951	12,886,276	2,527,359	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/18/2015 7:12 am

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS	831,525					6.00
7.00	00700	OPERATION OF PLANT	0	0				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,773	0	41,365			8.00
9.00	00900	HOUSEKEEPING	13,394	0	0	219,105		9.00
10.00	01000	DIETARY	42,401	0	0	13,258	187,533	10.00
11.00	01100	CAFETERIA	0	0	0	0	26,571	11.00
13.00	01300	NURSING ADMINISTRATION	2,154	0	0	674	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	35,725	0	0	11,171	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,650	0	0	1,454	0	16.00
17.00	01700	SOCIAL SERVICE	3,199	0	0	1,000	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	1,194	0	0	373	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	197,754	0	22,403	61,838	160,962	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	107,964	0	2,794	33,760	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	92,885	0	4,383	29,045	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	36,130	0	0	11,298	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	6,782	0	0	2,121	0	65.00
66.00	06600	PHYSICAL THERAPY	50,655	0	1,767	15,839	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	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,626	0	0	3,948	0	73.00
76.00	03950	SLEEP LAB	18,022	0	0	5,636	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	114,661	0	944	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	50,591	0	9,074	15,819	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	793,560	0	41,365	207,234	187,533	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,458	0	0	1,394	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	33,507	0	0	10,477	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	831,525	0	41,365	219,105	187,533	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/18/2015 7:12 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			11.00	13.00	14.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
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	26,571					11.00
13.00	01300	NURSING ADMINISTRATION	0	126,054				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	165,212			14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	192,877		16.00
17.00	01700	SOCIAL SERVICE	355	0	0	0	86,198	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,475	73,052	7,273	15,123	86,198	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	691	9,634	4,988	14,325	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,435	0	7,894	43,081	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	3,129	0	65,311	41,345	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	20	0	0	405	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,102	0	622	4,707	0	65.00
66.00	06600	PHYSICAL THERAPY	1,536	0	898	9,899	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	20,783	3,326	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	48,274	8,197	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	892	0	497	22,919	0	73.00
76.00	03950	SLEEP LAB	118	0	30	1,865	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,465	0	1,830	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,415	43,368	4,863	27,685	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,633	126,054	163,263	192,877	86,198	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	938	0	1,949	0	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	0	0	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	26,571	126,054	165,212	192,877	86,198	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/18/2015 7:12 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	241,242					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,113,190	0	2,113,190		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	241,242	771,500	0	771,500		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,244,314	0	1,244,314		54.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
60.00	06000	LABORATORY	0	1,517,061	0	1,517,061		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	4,338	0	4,338		63.00
65.00	06500	RESPIRATORY THERAPY	0	288,538	0	288,538		65.00
66.00	06600	PHYSICAL THERAPY	0	638,082	0	638,082		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	147,981	0	147,981		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	426,904	0	426,904		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	824,956	0	824,956		73.00
76.00	03950	SLEEP LAB	0	66,288	0	66,288		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,091,104	0	2,091,104		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	0	2,418,233	0	2,418,233		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	INFUSION CENTER	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	241,242	12,552,489	0	12,552,489		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,037	0	8,037		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	263,461	0	263,461		192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0		194.01
194.02	07952	MOBILE MEALS	0	0	0	0		194.02
194.03	07953	KIDNEY CENTER	0	57,184	0	57,184		194.03
194.04	07955	RETAIL PHARMACY	0	5,105	0	5,105		194.04
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	241,242	12,886,276	0	12,886,276		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/18/2015 7:12 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS FOUNDATION BLDG	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00570	ADMITTING	0	0	0	0	0	5.01
5.02	00590	HOSPITAL ONLY A & G	0	471	0	0	471	5.02
5.03	00591	SHARED ADMN & GENERAL	0	81,169	0	13,015	94,184	5.03
6.00	00600	MAINTENANCE & REPAIRS	0	36,837	0	22,006	58,843	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,092	0	0	1,092	8.00
9.00	00900	HOUSEKEEPING	0	5,277	0	0	5,277	9.00
10.00	01000	DIETARY	0	16,704	0	2,931	19,635	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	849	0	0	849	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,074	0	0	14,074	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,832	0	0	1,832	16.00
17.00	01700	SOCIAL SERVICE	0	1,260	0	0	1,260	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	471	0	4,060	4,531	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	77,908	0	7,152	85,060	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	42,534	0	8,623	51,157	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,593	0	55,579	92,172	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	14,234	0	831	15,065	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,672	0	0	2,672	65.00
66.00	06600	PHYSICAL THERAPY	0	19,956	0	0	19,956	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	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,974	0	1,640	6,614	73.00
76.00	03950	SLEEP LAB	0	7,100	0	0	7,100	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	19,931	0	4,300	24,231	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	385,938	0	120,137	506,075	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,756	0	0	1,756	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	13,200	0	0	13,200	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	400,894	0	120,137	521,031	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/18/2015 7:12 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMITTING	HOSPITAL ONLY A & G	SHARED ADMN & GENERAL	MAINTENANCE & REPAIRS	
			4.00	5.01	5.02	5.03	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.01	00570	ADMITTING	0	0				5.01
5.02	00590	HOSPITAL ONLY A & G	0	0	471			5.02
5.03	00591	SHARED ADMN & GENERAL	0	0	111	94,295		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	0	28	6,091	64,962	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	1	283	217	8.00
9.00	00900	HOUSEKEEPING	0	0	7	1,507	1,046	9.00
10.00	01000	DIETARY	0	0	4	966	3,313	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	4	903	168	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	4	867	2,791	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	6	1,368	363	16.00
17.00	01700	SOCIAL SERVICE	0	0	3	598	250	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	8	1,756	93	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	51	10,863	15,449	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	12	2,608	8,435	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	36	7,798	7,257	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	46	9,960	2,823	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	29	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	9	2,001	530	65.00
66.00	06600	PHYSICAL THERAPY	0	0	19	4,083	3,957	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	4	907	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	13	2,713	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	27	5,743	986	73.00
76.00	03950	SLEEP LAB	0	0	1	298	1,408	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	14,409	8,958	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	77	16,582	3,952	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	0	471	92,333	61,996	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	16	348	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	1,909	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	0	0	0	2,618	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	37	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	0	471	94,295	64,962	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/18/2015 7:12 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	0					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,593				8.00
9.00	00900	HOUSEKEEPING	0	0	7,837			9.00
10.00	01000	DIETARY	0	0	474	24,392		10.00
11.00	01100	CAFETERIA	0	0	0	3,456	3,456	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	24	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	400	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	52	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	36	0	46	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	13	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	863	2,210	20,936	712	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	108	1,208	0	90	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	169	1,039	0	317	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	404	0	407	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	3	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	76	0	143	65.00
66.00	06600	PHYSICAL THERAPY	0	68	567	0	200	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	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	141	0	116	73.00
76.00	03950	SLEEP LAB	0	0	202	0	15	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	36	0	0	841	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	349	566	0	444	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,593	7,412	24,392	3,334	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	50	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	122	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	0	375	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,593	7,837	24,392	3,456	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/18/2015 7:12 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			13.00	14.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,948					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	18,136				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	3,621			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	2,193		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	6,401	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,129	798	284	2,193		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	149	548	269	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	867	811	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0	0		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		58.00
60.00	06000	LABORATORY	0	7,169	775	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	8	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	68	88	0		65.00
66.00	06600	PHYSICAL THERAPY	0	99	186	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,281	62	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	5,299	154	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	55	430	0		73.00
76.00	03950	SLEEP LAB	0	3	35	0		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	201	0	0		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	670	534	519	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	INFUSION CENTER	0	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,948	17,922	3,621	2,193	0	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	214	0	0		192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0		194.01
194.02	07952	MOBILE MEALS	0	0	0	0		194.02
194.03	07953	KIDNEY CENTER	0	0	0	0		194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0		194.04
200.00		Cross Foot Adjustments					6,401	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,948	18,136	3,621	2,193	6,401	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/18/2015 7:12 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	FOUNDATION BLDG					1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570	ADMITTING					5.01
5.02	00590	HOSPITAL ONLY A & G					5.02
5.03	00591	SHARED ADMN & GENERAL					5.03
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	140,548	0	140,548		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	64,584	0	64,584		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,466	0	110,466		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	36,649	0	36,649		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	40	0	40		63.00
65.00	06500	RESPIRATORY THERAPY	5,587	0	5,587		65.00
66.00	06600	PHYSICAL THERAPY	29,135	0	29,135		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	3,254	0	3,254		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	8,179	0	8,179		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,112	0	14,112		73.00
76.00	03950	SLEEP LAB	9,062	0	9,062		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	24,445	0	24,445		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	47,924	0	47,924		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
93.00	04040	INFUSION CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0		117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	493,985	0	493,985		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,170	0	2,170		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,245	0	2,245		192.00
194.00	07950	BOARD OF HEALTH	0	0	0		194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0		194.01
194.02	07952	MOBILE MEALS	0	0	0		194.02
194.03	07953	KIDNEY CENTER	16,193	0	16,193		194.03
194.04	07955	RETAIL PHARMACY	37	0	37		194.04
200.00		Cross Foot Adjustments	6,401	0	6,401		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	521,031	0	521,031		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/18/2015 7:12 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	FOUNDATION BLDG (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMITTING (GROSS CHARGES)	
			1.00	1.01	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	47,711					1.00
1.01	00101	FOUNDATION BLDG	0	0				1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP			159,317			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	5,141,107		4.00
5.01	00570	ADMITTING	0	0	0	97,192	21,528,808	5.01
5.02	00590	HOSPITAL ONLY A & G	56	0	0	0	0	5.02
5.03	00591	SHARED ADMN & GENERAL	9,660	0	17,260	395,528	0	5.03
6.00	00600	MAINTENANCE & REPAIRS	4,384	0	29,183	131,252	0	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	130	0	0	22,898	0	8.00
9.00	00900	HOUSEKEEPING	628	0	0	42,348	0	9.00
10.00	01000	DIETARY	1,988	0	3,887	10,551	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	101	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,675	0	0	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	218	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	150	0	0	55,255	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	56	0	5,384	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,272	0	9,485	751,744	1,687,971	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,062	0	11,435	126,621	1,598,999	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,355	0	73,704	395,053	4,808,759	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,694	0	1,102	382,524	4,614,881	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	2,353	45,230	63.00
65.00	06500	RESPIRATORY THERAPY	318	0	0	162,396	525,389	65.00
66.00	06600	PHYSICAL THERAPY	2,375	0	0	285,375	1,104,926	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	371,219	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	914,902	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	592	0	2,175	235,809	2,558,174	73.00
76.00	03950	SLEEP LAB	845	0	0	19,365	208,153	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	1,133,922	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,372	0	5,702	637,214	3,090,205	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	45,931	0	159,317	4,887,400	21,528,808	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	209	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	253,707	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	1,571	0	0	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	400,894	0	120,137	723,226	118,541	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.402549	0.000000	0.754075	0.140675	0.005506	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000000	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/18/2015 7:12 am

		Cost Center Description	Reconciliation	HOSPITAL ONLY A & G (ACCUM. COST)	Reconciliation	SHARED ADMN & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5A.02	5.02	5A.03	5.03	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G	-156,951	10,919,865				5.02
5.03	00591	SHARED ADMN & GENERAL	0	2,491,549	-2,527,359	10,345,717		5.03
6.00	00600	MAINTENANCE & REPAIRS	0	658,804	0	668,273	38,987	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	0	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	30,576	0	31,015	130	8.00
9.00	00900	HOUSEKEEPING	0	162,981	0	165,324	628	9.00
10.00	01000	DIETARY	0	104,481	0	105,983	1,988	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	97,630	0	99,033	101	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	93,740	0	95,087	1,675	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	147,977	0	150,104	218	16.00
17.00	01700	SOCIAL SERVICE	0	64,685	0	65,615	150	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	189,891	0	192,620	56	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,175,045	0	1,191,934	9,272	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	282,134	0	286,189	5,062	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	843,458	0	855,581	4,355	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	1,077,386	0	1,092,871	1,694	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	3,100	0	3,145	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	216,455	0	219,566	318	65.00
66.00	06600	PHYSICAL THERAPY	0	441,689	0	448,037	2,375	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	98,141	0	99,552	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	293,488	0	297,706	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	621,209	0	630,138	592	73.00
76.00	03950	SLEEP LAB	0	32,180	0	32,643	845	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	-1,580,985	0	0	1,580,985	5,376	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	1,793,266	0	1,819,041	2,372	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,737,936	10,919,865	-2,527,359	10,130,442	37,207	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	-1,756	0	0	1,756	209	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-209,416	0	0	209,416	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	-13,200	0	-13,200	0	1,571	194.03
194.04	07955	RETAIL PHARMACY	-4,103	0	0	4,103	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		156,951		2,527,359	831,525	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.014373		0.244290	21.328263	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		471		94,295	64,962	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.000043		0.009114	1.666248	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/18/2015 7:12 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	0					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	40,693				8.00
9.00	00900	HOUSEKEEPING	0	0	32,853			9.00
10.00	01000	DIETARY	0	0	1,988	36,687		10.00
11.00	01100	CAFETERIA	0	0	0	5,198	8,076	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	101	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,675	0	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	218	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	150	0	108	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	56	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	22,038	9,272	31,489	1,664	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,749	5,062	0	210	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,312	4,355	0	740	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	1,694	0	951	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	6	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	318	0	335	65.00
66.00	06600	PHYSICAL THERAPY	0	1,738	2,375	0	467	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	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	592	0	271	73.00
76.00	03950	SLEEP LAB	0	0	845	0	36	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	929	0	0	1,965	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	8,927	2,372	0	1,038	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	40,693	31,073	36,687	7,791	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	209	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	285	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	0	1,571	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	41,365	219,105	187,533	26,571	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	1.016514	6.669254	5.111702	3.290119	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	1,593	7,837	24,392	3,456	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	0.039147	0.238547	0.664868	0.427935	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/18/2015 7:12 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (TIME SPENT)	
			13.00	14.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	FOUNDATION BLDG						1.01
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570	ADMITTING						5.01
5.02	00590	HOSPITAL ONLY A & G						5.02
5.03	00591	SHARED ADMN & GENERAL						5.03
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	56,746					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	860,288				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	21,528,808			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	169		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	32,886	37,872	1,687,971	169	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,337	25,975	1,598,999	0	100	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	41,105	4,808,759	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	340,085	4,614,881	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	45,230	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,240	525,389	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,676	1,104,926	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	108,220	371,219	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	251,369	914,902	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,587	2,558,174	0	0	73.00
76.00	03950	SLEEP LAB	0	158	208,153	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	9,530	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	19,523	25,323	3,090,205	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	56,746	850,140	21,528,808	169	100	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	10,148	0	0	0	192.00
194.00	07950	BOARD OF HEALTH	0	0	0	0	0	194.00
194.01	07951	VACANT PHYSICIAN OFFICE	0	0	0	0	0	194.01
194.02	07952	MOBILE MEALS	0	0	0	0	0	194.02
194.03	07953	KIDNEY CENTER	0	0	0	0	0	194.03
194.04	07955	RETAIL PHARMACY	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	126,054	165,212	192,877	86,198	241,242	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.221372	0.192043	0.008959	510.047337	2,412.420000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,948	18,136	3,621	2,193	6,401	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.034328	0.021081	0.000168	12.976331	64.010000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/18/2015 7:12 am

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	2,113,190		2,113,190	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	771,500		771,500	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,244,314		1,244,314	0	0	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,517,061		1,517,061	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,338		4,338	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	288,538	0	288,538	0	0	65.00
66.00	06600	PHYSICAL THERAPY	638,082	0	638,082	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	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	147,981		147,981	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	426,904		426,904	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	824,956		824,956	0	0	73.00
76.00	03950	SLEEP LAB	66,288		66,288	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,091,104		2,091,104	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,418,233		2,418,233	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	218,487		218,487		0	92.00
93.00	04040	INFUSION CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00		Subtotal (see instructions)	12,770,976	0	12,770,976	0	0	200.00
201.00		Less Observation Beds	218,487		218,487		0	201.00
202.00		Total (see instructions)	12,552,489	0	12,552,489	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/18/2015 7:12 am

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	1,499,046		1,499,046			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,631	1,574,368	1,598,999	0.482489	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	145,036	4,663,723	4,808,759	0.258760	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	363,361	4,251,520	4,614,881	0.328732	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	15,113	30,117	45,230	0.095910	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	227,437	297,952	525,389	0.549189	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	387,420	717,506	1,104,926	0.577488	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	154,890	216,329	371,219	0.398635	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	914,902	914,902	0.466612	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,452,377	1,105,797	2,558,174	0.322478	0.000000	73.00
76.00	03950	SLEEP LAB	0	208,153	208,153	0.318458	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,913,853	3,913,853			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	37,565	3,052,640	3,090,205	0.782548	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,418	180,507	188,925	1.156475	0.000000	92.00
93.00	04040	INFUSION CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	4,315,294	21,127,367	25,442,661			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,315,294	21,127,367	25,442,661			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/18/2015 7:12 am

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	05600	RADIOISOTOPE	0.000000		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	SLEEP LAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	INFUSION CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS			117.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/18/2015 7:12 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,113,190		2,113,190	0	2,113,190	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	771,500		771,500	0	771,500	50.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,244,314		1,244,314	0	1,244,314	54.00
56.00	05600	RADIOISOTOPE	0		0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
60.00	06000	LABORATORY	1,517,061		1,517,061	0	1,517,061	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,338		4,338	0	4,338	63.00
65.00	06500	RESPIRATORY THERAPY	288,538	0	288,538	0	288,538	65.00
66.00	06600	PHYSICAL THERAPY	638,082	0	638,082	0	638,082	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	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	147,981		147,981	0	147,981	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	426,904		426,904	0	426,904	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	824,956		824,956	0	824,956	73.00
76.00	03950	SLEEP LAB	66,288		66,288	0	66,288	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,091,104		2,091,104	0	2,091,104	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	2,418,233		2,418,233	0	2,418,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	218,487		218,487		218,487	92.00
93.00	04040	INFUSION CENTER	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0		0		0	117.00
200.00		Subtotal (see instructions)	12,770,976	0	12,770,976	0	12,770,976	200.00
201.00		Less Observation Beds	218,487		218,487		218,487	201.00
202.00		Total (see instructions)	12,552,489	0	12,552,489	0	12,552,489	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/18/2015 7:12 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,499,046		1,499,046			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,631	1,574,368	1,598,999	0.482489	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	145,036	4,663,723	4,808,759	0.258760	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	0.000000	58.00
60.00	06000	LABORATORY	363,361	4,251,520	4,614,881	0.328732	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	15,113	30,117	45,230	0.095910	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	227,437	297,952	525,389	0.549189	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	387,420	717,506	1,104,926	0.577488	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	154,890	216,329	371,219	0.398635	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	914,902	914,902	0.466612	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,452,377	1,105,797	2,558,174	0.322478	0.000000	73.00
76.00	03950	SLEEP LAB	0	208,153	208,153	0.318458	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,913,853	3,913,853	0.534283	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	37,565	3,052,640	3,090,205	0.782548	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	8,418	180,507	188,925	1.156475	0.000000	92.00
93.00	04040	INFUSION CENTER	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS	0	0	0			117.00
200.00		Subtotal (see instructions)	4,315,294	21,127,367	25,442,661			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	4,315,294	21,127,367	25,442,661			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/18/2015 7:12 am

Title XIX | 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	05600	RADIOISOTOPE	0.000000		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03950	SLEEP LAB	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
93.00	04040	INFUSION CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
117.00	06951	OTHER SPECIAL PURPOSE COST CENTERS			117.00
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: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/18/2015 7:12 am

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	64,584	1,598,999	0.040390	7,381	298	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	110,466	4,808,759	0.022972	61,606	1,415	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
60.00	06000	LABORATORY	36,649	4,614,881	0.007941	139,694	1,109	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	40	45,230	0.000884	2,907	3	63.00
65.00	06500	RESPIRATORY THERAPY	5,587	525,389	0.010634	87,158	927	65.00
66.00	06600	PHYSICAL THERAPY	29,135	1,104,926	0.026368	12,825	338	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,254	371,219	0.008766	50,837	446	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	8,179	914,902	0.008940	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,112	2,558,174	0.005516	521,760	2,878	73.00
76.00	03950	SLEEP LAB	9,062	208,153	0.043535	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	24,445	3,913,853	0.006246	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	47,924	3,090,205	0.015508	17,024	264	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	37,817	188,925	0.200169	7,015	1,404	92.00
93.00	04040	INFUSION CENTER	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	391,254	23,943,615		908,207	9,082	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/18/2015 7:12 am

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	241,242	0	0	0	241,242	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	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	INFUSION CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	241,242	0	0	0	241,242	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/18/2015 7:12 am

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	1,598,999	0.150871	0.000000	7,381	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,808,759	0.000000	0.000000	61,606	54.00
56.00	05600	RADIOISOTOPE	0	0	0.000000	0.000000	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	4,614,881	0.000000	0.000000	139,694	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	45,230	0.000000	0.000000	2,907	63.00
65.00	06500	RESPIRATORY THERAPY	0	525,389	0.000000	0.000000	87,158	65.00
66.00	06600	PHYSICAL THERAPY	0	1,104,926	0.000000	0.000000	12,825	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	371,219	0.000000	0.000000	50,837	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	914,902	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,558,174	0.000000	0.000000	521,760	73.00
76.00	03950	SLEEP LAB	0	208,153	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,913,853	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	3,090,205	0.000000	0.000000	17,024	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	188,925	0.000000	0.000000	7,015	92.00
93.00	04040	INFUSION CENTER	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	23,943,615			908,207	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/18/2015 7:12 am

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	1,114	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	05600	RADIOISOTOPE	0	0	0		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	SLEEP LAB	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	INFUSION CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	1,114	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/18/2015 7:12 am

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	0.482489	0	632,780	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.258760	0	1,364,760	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.328732	0	1,535,973	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.095910	0	12,082	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.549189	0	124,846	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.577488	0	313,134	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.398635	0	100,237	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0.466612	0	226,116	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322478	0	414,279	2,455	0	73.00
76.00	03950	SLEEP LAB	0.318458	0	61,228	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.782548	0	820,473	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.156475	0	97,684	0	0	92.00
93.00	04040	INFUSION CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	5,703,592	2,455	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	5,703,592	2,455	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/18/2015 7:12 am

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	305,309	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	353,145	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	504,923	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,159	0		63.00
65.00	06500	RESPIRATORY THERAPY	68,564	0		65.00
66.00	06600	PHYSICAL THERAPY	180,831	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	39,958	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	105,508	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	133,596	792		73.00
76.00	03950	SLEEP LAB	19,499	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	642,060	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	112,969	0		92.00
93.00	04040	INFUSION CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	2,467,521	792		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	2,467,521	792		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141304 | Component CCN: 14Z304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/18/2015 7:12 am

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	0.482489	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.258760	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY	0.328732	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.095910	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.549189	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.577488	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.398635	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0.466612	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322478	0	0	0	0	73.00
76.00	03950	SLEEP LAB	0.318458	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.782548	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.156475	0	0	0	0	92.00
93.00	04040	INFUSION CENTER	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		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: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/18/2015 7:12 am

Component CCN: 14Z304 | 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	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	SLEEP LAB	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	INFUSION CENTER	0	0		93.00
		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: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/18/2015 7:12 am

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)	1,928	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	721	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)	527	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	640	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)	508	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	23	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)	36	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	343	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)	461	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)	409	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	137.31	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	142.80	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,113,190	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)	3,158	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)	5,141	25.00
26.00	Total swing-bed cost (see instructions)	1,301,188	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	812,002	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)	812,002	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)	1,126.21	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	386,290	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)	386,290	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/18/2015 7:12 am

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)	330,931	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	717,221	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)	519,183	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	460,620	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	979,803	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)	194	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,126.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	218,487	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/18/2015 7:12 am

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	140,548	812,002	0.173088	218,487	37,817	90.00
91.00	Nursing School cost	0	812,002	0.000000	218,487	0	91.00
92.00	Allied health cost	0	812,002	0.000000	218,487	0	92.00
93.00	All other Medical Education	0	812,002	0.000000	218,487	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/18/2015 7:12 am

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		316,040		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.482489	7,381	3,561	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.258760	61,606	15,941	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.328732	139,694	45,922	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.095910	2,907	279	63.00
65.00	06500	RESPIRATORY THERAPY	0.549189	87,158	47,866	65.00
66.00	06600	PHYSICAL THERAPY	0.577488	12,825	7,406	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.398635	50,837	20,265	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0.466612	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322478	521,760	168,256	73.00
76.00	03950	SLEEP LAB	0.318458	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.782548	17,024	13,322	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.156475	7,015	8,113	92.00
93.00	04040	INFUSION CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		908,207	330,931	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)		908,207		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141304 | Component CCN: 14Z304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/18/2015 7:12 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.482489	10,544	5,087	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.258760	36,986	9,570	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	56.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
60.00	06000	LABORATORY	0.328732	117,258	38,546	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.095910	2,688	258	63.00
65.00	06500	RESPIRATORY THERAPY	0.549189	82,895	45,525	65.00
66.00	06600	PHYSICAL THERAPY	0.577488	265,574	153,366	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.398635	73,247	29,199	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIE	0.466612	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.322478	463,554	149,486	73.00
76.00	03950	SLEEP LAB	0.318458	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.782548	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.156475	0	0	92.00
93.00	04040	INFUSION CENTER	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,052,746	431,037	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,052,746		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141304	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/18/2015 7:12 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	2,468,313	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)	2,468,313	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)	2,492,996	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)	13,959	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	824,482	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)	1,654,555	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)	1,654,555	30.00
31.00	Primary payer payments	2,910	31.00
32.00	Subtotal (line 30 minus line 31)	1,651,645	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)	97,559	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	74,145	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	94,538	36.00
37.00	Subtotal (see instructions)	1,725,790	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,725,790	40.00
40.01	Sequestration adjustment (see instructions)	34,516	40.01
41.00	Interim payments	1,898,036	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-206,762	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: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/18/2015 7:12 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		454,597		2,039,435	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	02/12/2015	78,174		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	02/12/2015	141,399	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)		78,174		-141,399	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)		532,771		1,898,036	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		84,855		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		206,762	6.02
7.00	Total Medicare program liability (see instructions)		617,626		1,691,274	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: 141304 | Component CCN: 14Z304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/18/2015 7:12 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,097,687		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	02/12/2015	81,651		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)		81,651		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)		1,179,338		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		184,103		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,363,441		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: 141304	Period: From 07/01/2014 To 06/30/2015	Worksheet E-1 Part II Date/Time Prepared: 11/18/2015 7:12 am
	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	169	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	343	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	91	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	527	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	25,442,661	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	313,348	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	75,063	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	75,063	8.00
9.00	Sequestration adjustment amount (see instructions)	1,501	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	73,562	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)	73,562	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141304 Component CCN: 14Z304	Period: From 07/01/2014 To 06/30/2015	Worksheet E-2 Date/Time Prepared: 11/18/2015 7:12 am
	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)	989,601	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)	435,347	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	870	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)	1,424,948	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,424,948	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)	1,424,948	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	33,682	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)	1,391,266	0	15.00
16.00	OTHER	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)	1,391,266	0	19.00
19.01	Sequestration adjustment (see instructions)	27,825	0	19.01
20.00	Interim payments	1,179,338	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)	184,103	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: 141304	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part V Date/Time Prepared: 11/18/2015 7:12 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	717,221	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)	717,221	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	724,393	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)	724,393	19.00
20.00	Deductibles (exclude professional component)	106,151	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	618,242	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	618,242	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	15,775	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	11,989	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	15,532	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	630,231	28.00
29.00	OTHER	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)	630,231	30.00
30.01	Sequestration adjustment (see instructions)	12,605	30.01
31.00	Interim payments	532,771	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)	84,855	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: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/18/2015 7:12 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	442,494	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,548,348	0	0	0	4.00
5.00	Other receivable	23,571	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-1,611,841	0	0	0	6.00
7.00	Inventory	272,573	0	0	0	7.00
8.00	Prepaid expenses	75,587	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)	2,750,732	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	65,000	0	0	0	12.00
13.00	Land improvements	32,229	0	0	0	13.00
14.00	Accumulated depreciation	-5,050	0	0	0	14.00
15.00	Buildings	11,779,241	0	0	0	15.00
16.00	Accumulated depreciation	-424,101	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	1,901,186	0	0	0	19.00
20.00	Accumulated depreciation	-194,989	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	109,793	0	0	0	23.00
24.00	Accumulated depreciation	-56,897	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,206,412	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,448,475	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	754,872	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,203,347	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	18,160,491	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	544,939	0	0	0	37.00
38.00	Salaries, wages, and fees payable	426,692	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	747,323	0	0	0	40.00
41.00	Deferred income	110,513	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	704,592	0	0	0	43.00
44.00	Other current liabilities	1,174,204	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,708,263	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	8,552,677	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	88,703	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	8,641,380	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	12,349,643	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	5,810,848				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)	5,810,848	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	18,160,491	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/18/2015 7:12 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		3,120,727		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,241,636				2.00
3.00	Total (sum of line 1 and line 2)		4,362,363		0		3.00
4.00	TEMPORARY RESTRICTED ASSETS	1,448,475		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)		1,448,475		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,810,838		0		11.00
12.00	ROUNDING	-10		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)		-10		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,810,848		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	TEMPORARY RESTRICTED ASSETS		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	ROUNDING		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: 141304 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/18/2015 7:12 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	531,589		531,589	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	999,230		999,230	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)	1,530,819		1,530,819	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1,530,819		1,530,819	17.00
18.00	Ancillary services	2,719,082	14,399,105	17,118,187	18.00
19.00	Outpatient services	45,983	3,233,147	3,279,130	19.00
20.00	RURAL HEALTH CLINIC	0	3,913,853	3,913,853	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	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	22,696	2,211,413	2,234,109	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,318,580	23,757,518	28,076,098	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		13,733,333		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00		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)		13,733,333		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141304	Period: From 07/01/2014 To 06/30/2015	Worksheet G-3 Date/Time Prepared: 11/18/2015 7:12 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	28,076,098	1.00
2.00	Less contractual allowances and discounts on patients' accounts	14,476,182	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,599,916	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	13,733,333	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-133,417	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	65,977	6.00
7.00	Income from investments	5,124	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	7,174	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	24,522	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	357,873	16.00
17.00	Revenue from sale of drugs to other than patients	19,271	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	INTERCOMPANY REVENUE	0	24.00
24.01	OTHER REVENUE	53,684	24.01
24.02	RENTAL INCOME	18,395	24.02
24.03	EHR PAYMENTS	823,033	24.03
25.00	Total other income (sum of lines 6-24)	1,375,053	25.00
26.00	Total (line 5 plus line 25)	1,241,636	26.00
27.00	RECONCILING ITEM	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,241,636	29.00

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

Provider CCN: 141304 Component CCN: 143453 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/18/2015 7:12 am

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	504,064	31,666	535,730	-23	535,707	1.00
2.00	Physician Assistant	81,724	5,134	86,858	0	86,858	2.00
3.00	Nurse Practitioner	209,900	13,186	223,086	0	223,086	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	160,872	10,106	170,978	0	170,978	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	187,760	11,795	199,555	0	199,555	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,144,320	71,887	1,216,207	-23	1,216,184	10.00
11.00	Physician Services Under Agreement	0	38,678	38,678	0	38,678	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	3,578	3,578	0	3,578	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	42,256	42,256	0	42,256	14.00
15.00	Medical Supplies	0	10,128	10,128	-367	9,761	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	6,115	6,115	0	6,115	17.00
18.00	Professional Liability Insurance	0	250	250	-250	0	18.00
19.00	Other Health Care Costs	0	3,119	3,119	0	3,119	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	19,612	19,612	-617	18,995	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,144,320	133,755	1,278,075	-640	1,277,435	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	78,497	78,497	0	78,497	29.00
30.00	Administrative Costs	136,044	129,430	265,474	-146,442	119,032	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	136,044	207,927	343,971	-146,442	197,529	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,280,364	341,682	1,622,046	-147,082	1,474,964	32.00

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

Provider CCN: 141304 | Component CCN: 143453 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/18/2015 7:12 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-50,345	485,362		1.00
2.00	Physician Assistant	0	86,858		2.00
3.00	Nurse Practitioner	0	223,086		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	170,978		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	199,555		9.00
10.00	Subtotal (sum of lines 1 through 9)	-50,345	1,165,839		10.00
11.00	Physician Services Under Agreement	0	38,678		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	3,578		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	42,256		14.00
15.00	Medical Supplies	0	9,761		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	6,115		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	3,119		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	18,995		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-50,345	1,227,090		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	78,497		29.00
30.00	Administrative Costs	-3,151	115,881		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-3,151	194,378		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-53,496	1,421,468		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141304 | Component CCN: 143453 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-2 | Date/Time Prepared: 11/18/2015 7:12 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.43	9,618	4,200	10,206		1.00
2.00	Physician Assistant	0.68	1,624	2,100	1,428		2.00
3.00	Nurse Practitioner	1.19	5,363	2,100	2,499		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.30	16,605		14,133	16,605	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	0.06	160			160	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)	4.36	16,765			16,765	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)					1,227,090	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)					1,227,090	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)					194,378	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					669,636	15.00
16.00	Total overhead (sum of lines 14 and 15)					864,014	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					864,014	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					864,014	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,091,104	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141304 | Component CCN: 143453 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-3 | Date/Time Prepared: 11/18/2015 7:12 am

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		2,091,104	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		748	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,090,356	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		16,765	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)		16,765	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		124.69	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)	124.69	124.69	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,683	1,654	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	209,853	206,237	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) *		416,090	16.00
16.01	Total program charges (see instructions)(from contractor's records)		663,093	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		297,554	16.04
16.05	Total program cost (see instructions)		297,554	16.05
17.00	Primary payer amounts		2,253	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		44,148	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		123,032	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		295,301	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		225	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		295,526	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	SEQUESTRATION RECONCILIATION TO PS&R		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		295,526	26.00
26.01	Sequestration adjustment (see instructions)		5,911	26.01
27.00	Interim payments		354,390	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)		-64,775	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: 141304 | Component CCN: 143453 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-4 | Date/Time Prepared: 11/18/2015 7:12 am

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)	1,165,839	1,165,839	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000128	0.000128	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	149	149	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	141	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	290	149	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,227,090	1,227,090	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	864,014	864,014	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000236	0.000121	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	204	105	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	494	254	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	11	0	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	44.91	0.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	5	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	225	0	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)		748	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)		225	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141304 Component CCN: 143453	Period: From 07/01/2014 To 06/30/2015	Worksheet M-5 Date/Time Prepared: 11/18/2015 7:12 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		350,726	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		02/12/2015	3,664	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)		3,664	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		354,390	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		64,775	6.02
7.00	Total Medicare program liability (see instructions)		289,615	7.00

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