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: 141313	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/11/2016 11:38 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/11/2016 Time: 11:38 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 MASON DISTRICT HOSPITAL (141313) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	101,776	-251,457	0	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	117,419	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	29		0	9.00
10.00	RURAL HEALTH CLINIC I	0		98,826		0	10.00
10.01	RURAL HEALTH CLINIC II	0		18,172		0	10.01
200.00	Total	0	219,195	-134,430	0	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: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/10/2016 3:52 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 615 NORTH PROMENADE STREET	PO Box:			1.00
2.00	City: HAVANA	State: IL	Zip Code: 62644-0530	County: MASON	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	MASON DISTRICT HOSPITAL	141313	99914	1	07/01/2001	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	MASON DISTRICT HOSPITAL	14Z313	99914		07/01/2001	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	MASON DISTRICT HHA	147202	99914		01/09/1982	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	HAVANA MEDICAL ASSOCIATES RHC	143457	99914		02/01/2001	O	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	MASON CITY MEDICAL ASSOCIATES	143462	99914		03/03/2003	O	O	O	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2014	09/30/2015	20.00
21.00	Type of Control (see instructions)	11		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.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	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: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/10/2016 3:52 pm

		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)				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: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/10/2016 3:52 pm

		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: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/10/2016 3:52 pm

		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.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	60,283	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.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141313	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/10/2016 3:52 pm

			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)		N		140.00

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

			1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00
		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
			1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N	149.00

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

						1.00	
	Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00 166.00

			1.00
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		0 168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00 169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2015	03/31/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141313	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/10/2016 3:52 pm

			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: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/10/2016 3:52 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			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	01/08/2016	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: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/10/2016 3:52 pm

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563.888.4404	DAN.LINHART@MCGLADREY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/10/2016 3:52 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	01/08/2016			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/10/2016 3:52 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	13,577.60	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	13,577.60	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	0	0	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	13,577.60	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/10/2016 3:52 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	401	43	602			1.00
2.00	HMO and other (see instructions)	79	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	375	0	403			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	30			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	776	43	1,035			7.00
8.00	INTENSIVE CARE UNIT	0	0	0			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	776	43	1,035	0.00	160.35	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	4,564	525	19,615	0.00	9.51	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	4,093	3,146	12,817	0.00	29.99	26.00
26.01	RURAL HEALTH CLINIC II	250	640	1,821	0.00	4.02	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	203.87	27.00
28.00	Observation Bed Days		0	113			28.00
29.00	Ambulance Trips	664					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: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/10/2016 3:52 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	149	17	224	1.00
2.00	HMO and other (see instructions)			22	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	149	17	224	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 141313 | Component CCN: 147202 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-4 | Date/Time Prepared: 2/10/2016 3:52 pm

Home Health Agency I | PPS

		1.00	
0.00	County	MASON	0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	757	39	280	1,076	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	192.00	10.00	71.00	273.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent)			
			Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	40.00	1.00	0.00	1.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel		2.01	0.00	2.01	5.00
6.00	Direct Nursing Service		5.98	0.00	5.98	6.00
7.00	Nursing Supervisor		0.00	0.00	0.00	7.00
8.00	Physical Therapy Service		0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		0.00	0.00	0.00	15.00
16.00	Home Health Aide		0.52	0.00	0.52	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2				19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99914				20.00
20.01			99915				20.01

		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	2,636	186	41	46	2,909	21.00
22.00	Skilled Nursing Visit Charges	649,844	45,942	10,127	11,330	717,243	22.00
23.00	Physical Therapy Visits	1,021	10	2	37	1,070	23.00
24.00	Physical Therapy Visit Charges	278,197	2,730	546	10,069	291,542	24.00
25.00	Occupational Therapy Visits	337	1	1	12	351	25.00
26.00	Occupational Therapy Visit Charges	91,817	273	273	3,268	95,631	26.00
27.00	Speech Pathology Visits	60	0	7	0	67	27.00
28.00	Speech Pathology Visit Charges	16,252	0	1,911	0	18,163	28.00
29.00	Medical Social Service Visits	2	0	0	0	2	29.00
30.00	Medical Social Service Visit Charges	530	0	0	0	530	30.00
31.00	Home Health Aide Visits	159	6	0	0	165	31.00
32.00	Home Health Aide Visit Charges	21,727	822	0	0	22,549	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4,215	203	51	95	4,564	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,058,367	49,767	12,857	24,667	1,145,658	35.00
36.00	Total Number of Episodes (standard/non outlier)	227		18	4	249	36.00
37.00	Total Number of Outlier Episodes		6		1	7	37.00
38.00	Total Non-Routine Medical Supply Charges	5,087	1,660	100	0	6,847	38.00

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

Provider CCN: 141313 Component CCN: 143457 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-8 Date/Time Prepared: 2/10/2016 3:52 pm

		Rural Health Clinic (RHC) I	Cost	
		1.00		
	Clinic Address and Identification			
1.00	Street	615 PROMENADE BOX 530		1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	HAVANA	IL	62644-0530 2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

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

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		MASON				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	17:00	08:00	17:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2014 To 09/30/2015	Worksheet S-8 Date/Time Prepared: 2/10/2016 3:52 pm
		Rural Health Clinic (RHC) I	Cost

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

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

Provider CCN: 141313 Component CCN: 143462 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-8 Date/Time Prepared: 2/10/2016 3:52 pm

				Rural Health Clinic (RHC) II	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			615 N PROMENADE		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	HAVANA		IL	62644	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

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

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

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

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

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

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

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

Provider CCN: 141313
Component CCN: 143462

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-8

Date/Time Prepared:
2/10/2016 3:52 pm

Rural Health Clinic (RHC) II

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-10 | Date/Time Prepared: 2/10/2016 3:52 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.592338	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,379,445	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	1,194,248	5.00
6.00	Medicaid charges	3,829,260	6.00
7.00	Medicaid cost (line 1 times line 6)	2,268,216	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	9,347	9.00
10.00	Stand-alone SCHIP charges	21,443	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	12,702	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	3,355	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	1,264,544	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	3,355	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	38,387	42,594	80,981	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	22,738	25,230	47,968	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)	22,738	25,230	47,968	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,211,159	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	238,656	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	972,503	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	576,050	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	624,018	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	627,373	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		401	401	255,648	256,049	1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING		0	0	65,683	65,683	1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG		0	0	542,481	542,481	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,310,880	1,310,880	-539,248	771,632	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,528,078	2,528,078	0	2,528,078	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	1,219,816	1,126,254	2,346,070	0	2,346,070	5.01
5.02	00591	A&G HOSPITAL ONLY	291,346	188,422	479,768	0	479,768	5.02
6.00	00600	MAINTENANCE & REPAIRS	257,168	240,943	498,111	0	498,111	6.00
7.00	00700	OPERATION OF PLANT	0	226,514	226,514	0	226,514	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	20,123	20,123	0	20,123	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	32,976	17,044	50,020	0	50,020	8.00
9.00	00900	HOUSEKEEPING	215,576	66,324	281,900	0	281,900	9.00
10.00	01000	DIETARY	212,948	180,060	393,008	0	393,008	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	139,022	12,638	151,660	0	151,660	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	65,019	15,715	80,734	0	80,734	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	146,023	63,236	209,259	0	209,259	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	298,567	298,567	0	298,567	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	966,367	166,660	1,133,027	0	1,133,027	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	217,678	12,702	230,380	0	230,380	50.00
53.00	05300	ANESTHESIOLOGY	0	285	285	0	285	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	539,212	270,352	809,564	-104,035	705,529	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	62,538	60,639	123,177	3,318	126,495	54.01
56.00	05600	RADIOISOTOPE	38,477	77,808	116,285	689	116,974	56.00
58.00	05800	MRI	0	103,192	103,192	1,520	104,712	58.00
60.00	06000	LABORATORY	576,577	567,672	1,144,249	77,490	1,221,739	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	49,608	49,608	0	49,608	62.00
64.00	06400	INTRAVENOUS THERAPY	0	10,441	10,441	0	10,441	64.00
66.00	06600	PHYSICAL THERAPY	453,627	126,991	580,618	0	580,618	66.00
67.00	06700	OCCUPATIONAL THERAPY	149,113	25,116	174,229	0	174,229	67.00
68.00	06800	SPEECH PATHOLOGY	9,963	2,864	12,827	0	12,827	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	341,801	131,911	473,712	21,018	494,730	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	336,464	336,464	0	336,464	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	277,582	379,213	656,795	0	656,795	73.00
76.00	03020	OP SENIOR HEALTH	152,487	119,166	271,653	0	271,653	76.00
76.01	03550	TELEMEDICINE PSYCH	4,269	14,090	18,359	0	18,359	76.01
76.02	03950	DIABETIC EDUCATION	12,796	2,308	15,104	0	15,104	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,440,191	475,295	2,915,486	-165,457	2,750,029	88.00
88.01	08801	RURAL HEALTH CLINIC II	283,220	56,052	339,272	0	339,272	88.01
91.00	09100	EMERGENCY	331,598	1,363,301	1,694,899	523,078	2,217,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	853,807	97,047	950,854	-523,078	427,776	95.00
101.00	10100	HOME HEALTH AGENCY	471,332	96,647	567,979	0	567,979	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		324,564	324,564	-324,564	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,762,529	11,165,587	21,928,116	-165,457	21,762,659	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	23,326	1,611	24,937	165,457	190,394	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		TOTAL (SUM OF LINES 118-199)	10,785,855	11,167,198	21,953,053	0	21,953,053	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,619	260,668		1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	65,683		1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	-7,835	534,646		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-154,455	617,177		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-677,660	1,850,418		4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	-51,112	2,294,958		5.01
5.02	00591	A&G HOSPITAL ONLY	-3,106	476,662		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	498,111		6.00
7.00	00700	OPERATION OF PLANT	-254	226,260		7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	20,123		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	50,020		8.00
9.00	00900	HOUSEKEEPING	0	281,900		9.00
10.00	01000	DIETARY	-137,923	255,085		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	151,660		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	80,734		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-5,965	203,294		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	298,567		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,133,027		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	230,380		50.00
53.00	05300	ANESTHESIOLOGY	0	285		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-30,310	675,219		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	126,495		54.01
56.00	05600	RADIOISOTOPE	0	116,974		56.00
58.00	05800	MRI	0	104,712		58.00
60.00	06000	LABORATORY	-70	1,221,669		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	49,608		62.00
64.00	06400	INTRAVENOUS THERAPY	0	10,441		64.00
66.00	06600	PHYSICAL THERAPY	0	580,618		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	174,229		67.00
68.00	06800	SPEECH PATHOLOGY	0	12,827		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	-46,682	448,048		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	336,464		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	656,795		73.00
76.00	03020	OP SENIOR HEALTH	0	271,653		76.00
76.01	03550	TELEMEDICINE PSYCH	0	18,359		76.01
76.02	03950	DIABETIC EDUCATION	0	15,104		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-435	2,749,594		88.00
88.01	08801	RURAL HEALTH CLINIC II	-287	338,985		88.01
91.00	09100	EMERGENCY	-319,654	1,898,323		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	427,776		95.00
101.00	10100	HOME HEALTH AGENCY	-3,300	564,679		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,434,429	20,328,230		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	190,394		192.00
194.00	07950	HOSPICE	0	0		194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0		194.01
194.02	07952	MEALS ON WHEELS	0	0		194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0		194.04
200.00		TOTAL (SUM OF LINES 118-199)	-1,434,429	20,518,624		200.00

RECLASSIFICATIONS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/10/2016 3:52 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	71,221		1.00
2.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	253,343		2.00
	TOTALS		0	324,564		
	B - EMS SALARY TO ER					
1.00	EMERGENCY	91.00	523,078	0		1.00
	TOTALS		523,078	0		
	C - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	184,427		1.00
2.00	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	65,683		2.00
3.00	NEW CAP REL COSTS-NEW MED SURG	1.02	0	289,138		3.00
	TOTALS		0	539,248		
	D - RHC PHYSICIAN					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	165,457	0		1.00
	TOTALS		165,457	0		
	E - OP REGISTRATION					
1.00	LABORATORY	60.00	68,707	8,783		1.00
2.00	CARDIOPULMONARY	69.01	18,636	2,382		2.00
3.00	RADIOLOGY-ULTRASOUND	54.01	2,942	376		3.00
4.00	RADIOISOTOPE	56.00	611	78		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	4,947	632		5.00
6.00	MRI	58.00	1,348	172		6.00
	TOTALS		97,191	12,423		
500.00	Grand Total: Increases		785,726	876,235		500.00

RECLASSIFICATIONS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/10/2016 3:52 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	324,564	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	324,564			
	B - EMS SALARY TO ER						
1.00	AMBULANCE SERVICES	95.00	523,078	0	0		1.00
	TOTALS		523,078	0			
	C - DEPRECIATION						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	539,248	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	539,248			
	D - RHC PHYSICIAN						
1.00	RURAL HEALTH CLINIC	88.00	165,457	0	0		1.00
	TOTALS		165,457	0			
	E - OP REGISTRATION						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	97,191	12,423	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	TOTALS		97,191	12,423			
500.00	Grand Total: Decreases		785,726	876,235			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 2/10/2016 3:52 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	163,928	0	0	0	0	1.00
2.00	Land Improvements	582,643	0	0	0	0	2.00
3.00	Buildings and Fixtures	14,483,271	191,526	0	191,526	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,385,102	26,272	0	26,272	0	5.00
6.00	Movable Equipment	7,912,326	528,694	0	528,694	0	6.00
7.00	HIT designated Assets	810,377	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	27,337,647	746,492	0	746,492	0	8.00
9.00	Reconciling Items	-371,992	-112,059	0	-112,059	0	9.00
10.00	Total (line 8 minus line 9)	27,709,639	858,551	0	858,551	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	163,928	0	1.00
2.00	Land Improvements	582,643	0	2.00
3.00	Buildings and Fixtures	14,674,797	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	3,411,374	0	5.00
6.00	Movable Equipment	8,441,020	0	6.00
7.00	HIT designated Assets	810,377	0	7.00
8.00	Subtotal (sum of lines 1-7)	28,084,139	0	8.00
9.00	Reconciling Items	-484,051	0	9.00
10.00	Total (line 8 minus line 9)	28,568,190	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 2/10/2016 3:52 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	401	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	1,310,880	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,311,281	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	401		1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0		1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0		1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,310,880		2.00
3.00	Total (sum of lines 1-2)	0	1,311,281		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III | Date/Time Prepared: 2/10/2016 3:52 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	19,316,793	0	19,316,793	0.676164	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	9,251,397	0	9,251,397	0.323836	0	2.00
3.00	Total (sum of lines 1-2)	28,568,190	0	28,568,190	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	166,454	0	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	65,683	0	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	0	0	0	287,936	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	617,177	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,137,250	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	69,434	0	0	24,780	260,668	1.00
1.01	NEW CAP REL COSTS-CLINIC BUILDING	0	0	0	0	65,683	1.01
1.02	NEW CAP REL COSTS-NEW MED SURG	246,710	0	0	0	534,646	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	617,177	2.00
3.00	Total (sum of lines 1-2)	316,144	0	0	24,780	1,478,174	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/10/2016 3:52 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - NEW CAP REL COSTS-CLINIC BUILDING (chapter 2)		0	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-NEW MED SURG (chapter 2)		0	NEW CAP REL COSTS-NEW MED SURG	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-380,831			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-CLINIC BUILDING		0	NEW CAP REL COSTS-CLINIC BUILDING	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-NEW MED SURG		0	NEW CAP REL COSTS-NEW MED SURG	1.02	0	26.02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/10/2016 3:52 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-154,455	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MEDICAL RECORD FEES -OTHER OP	B	-5,965	MEDICAL RECORDS & LIBRARY	16.00	0	33.00
33.01	CAFETERIA SALES -OTHER OP	B	-136,123	DIETARY	10.00	0	33.01
33.02	DIETARY CONSULT -OTHER OP	B	-1,800	DIETARY	10.00	0	33.02
33.03	SALE OF NON-PAT SUPP-OTHER OP	B	-8,262	ADMINISTRATIVE AND GENERAL	5.01	0	33.03
33.04			0		0.00	0	33.04
33.05	PROF BUILDING RENT -OTHER OP	B	-15,424	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06	MISCELLANEOUS -OTHER OP	B	-2,935	ADMINISTRATIVE AND GENERAL	5.01	0	33.06
33.07	RENTAL INCOME	B	-2,950	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
33.08			0		0.00	0	33.08
33.09	COMMUNITY ED FEES -OTHER OP	B	-2,115	ADMINISTRATIVE AND GENERAL	5.01	0	33.09
33.10	LAB OUTREACH REV -OTHER OP	B	-70	LABORATORY	60.00	0	33.10
33.11			0		0.00	0	33.11
33.12	INTEREST INCOME -NON OPER	B	-1,787	CAP REL COSTS-BLDG & FIXT	1.00	11	33.12
33.13	INTEREST INCOME -NON OPER	B	-6,633	NEW CAP REL COSTS-NEW MED SURG	1.02	11	33.13
33.14	FITNESS REV OTHER	B	-5,080	CARDIOPULMONARY	69.01	0	33.14
33.15	FITNESS CENTER REV	B	-10,735	CARDIOPULMONARY	69.01	0	33.15
33.16	TELEPHONE OFFSET - OPERATIONS	A	-254	OPERATION OF PLANT	7.00	0	33.16
33.17	TELEPHONE OFFSET - SALARIES	A	-70	ADMINISTRATIVE AND GENERAL	5.01	0	33.17
33.18	TELEPHONE OFFSET - BENEFITS	A	-11	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.18
33.19	MEDICAR - EXPENSES	A	-13,167	ADMINISTRATIVE AND GENERAL	5.01	0	33.19
33.20	MEDICAR - BENEFITS	A	-1,641	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21	LOBBYING DUES	A	-3,103	ADMINISTRATIVE AND GENERAL	5.01	0	33.21
33.22	ADVERTISING	A	-14,620	ADMINISTRATIVE AND GENERAL	5.01	0	33.22
33.23			0		0.00	0	33.23
33.24			0		0.00	0	33.24
33.25	ADVERTISING	A	-3,106	A&G HOSPITAL ONLY	5.02	0	33.25
33.26			0		0.00	0	33.26
33.27	ADVERTISING	A	-435	RURAL HEALTH CLINIC	88.00	0	33.27
33.28	ADVERTISING	A	-287	RURAL HEALTH CLINIC II	88.01	0	33.28
33.29			0		0.00	0	33.29
33.30			0		0.00	0	33.30
33.31			0		0.00	0	33.31
33.32			0		0.00	0	33.32
33.33			0		0.00	0	33.33
33.34	TELEVISIONS	A	-1,202	NEW CAP REL COSTS-NEW MED SURG	1.02	9	33.34
33.35	SELF INSURANCE	A	-475,107	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.35
33.36	UNFUNDED POST-EMPLOYMENT BENEFIT	A	-54,000	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.36
33.37	NON-ALLOW DONATION EXP	A	-6,840	ADMINISTRATIVE AND GENERAL	5.01	0	33.37
33.38	BOND AMORTIZTION COST FY14	A	24,780	CAP REL COSTS-BLDG & FIXT	1.00	14	33.38
33.39	HOME HEALTH BLDG RENT	B	-3,300	HOME HEALTH AGENCY	101.00	0	33.39
33.40	IMRF CONTRIBUTION	A	-146,901	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.40
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,434,429				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/10/2016 3:52 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	1,257,984	319,654	938,330	0	0	1.00
2.00	60.00	LABORATORY	68,000	0	68,000	0	0	2.00
3.00	69.01	CARDIOPULMONARY	30,867	30,867	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	30,310	30,310	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			1,387,161	380,831	1,006,330		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	EMERGENCY	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	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	EMERGENCY	0	0	0	319,654		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.01	CARDIOPULMONARY	0	0	0	30,867		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	30,310		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	380,831		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/10/2016 3:52 pm

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					8	1.00
2.00	Line 1 multiplied by 15 hours per week					120	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	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					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	267.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	79.57	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)	39.79	39.79	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)					21,245	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)					21,245	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)					21,245	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)					21,245	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)					0	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)					0	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)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	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)					0	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: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 2/10/2016 3:52 pm

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)	79.57	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)	21,245		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0		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)	21,245		63.00
64.00	Total cost of outside supplier services (from your records)	16,020		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	0		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0		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	0		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	0		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: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	260,668	260,668				1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	65,683	0	65,683			1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	534,646	0	0	534,646		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	617,177				617,177	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,850,418	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	2,294,958	52,434	3,484	73,932	27,522	5.01
5.02	00591	A&G HOSPITAL ONLY	476,662	2,575	4,291	4,389	2,106	5.02
6.00	00600	MAINTENANCE & REPAIRS	498,111	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	226,260	26,793	550	11,703	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	20,123	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	50,020	7,891	0	4,349	3,089	8.00
9.00	00900	HOUSEKEEPING	281,900	946	0	2,570	0	9.00
10.00	01000	DIETARY	255,085	12,827	0	0	720	10.00
11.00	01100	CAFETERIA	0	5,453	0	2,965	0	11.00
13.00	01300	NURSING ADMINISTRATION	151,660	5,316	0	6,365	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	80,734	6,859	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	203,294	6,474	668	0	93,473	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	298,567	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,133,027	3,905	0	416,789	21,889	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	230,380	31,573	0	0	87,609	50.00
53.00	05300	ANESTHESIOLOGY	285	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	675,219	23,768	0	0	183,588	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	126,495	1,229	0	0	0	54.01
56.00	05600	RADIOISOTOPE	116,974	2,671	0	0	0	56.00
58.00	05800	MRI	104,712	0	0	0	0	58.00
60.00	06000	LABORATORY	1,221,669	13,692	0	0	5,261	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	49,608	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	10,441	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	580,618	5,210	0	0	82,425	66.00
67.00	06700	OCCUPATIONAL THERAPY	174,229	1,093	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	12,827	789	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	448,048	24,613	0	0	15,284	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	336,464	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	656,795	3,885	0	0	0	73.00
76.00	03020	OP SENIOR HEALTH	271,653	0	2,795	0	0	76.00
76.01	03550	TELEMEDICINE PSYCH	18,359	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	15,104	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,749,594	0	48,204	0	8,285	88.00
88.01	08801	RURAL HEALTH CLINIC II	338,985	0	0	0	983	88.01
91.00	09100	EMERGENCY	1,898,323	20,672	0	0	1,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	427,776	0	0	0	77,025	95.00
101.00	10100	HOME HEALTH AGENCY	564,679	0	5,691	0	6,498	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,328,230	260,668	65,683	523,062	616,975	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,584	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	190,394	0	0	0	202	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	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)	20,518,624	260,668	65,683	534,646	617,177	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	A&G HOSPITAL ONLY	
			4.00	4A	5.01	5A.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,850,418					4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	207,727	2,660,057	2,660,057			5.01
5.02	00591	A&G HOSPITAL ONLY	50,030	540,053	80,441	620,494	620,494	5.02
6.00	00600	MAINTENANCE & REPAIRS	44,161	542,272	80,772	623,044	26,180	6.00
7.00	00700	OPERATION OF PLANT	0	265,306	39,518	304,824	12,809	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	20,123	2,997	23,120	972	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	5,663	71,012	10,577	81,589	3,428	8.00
9.00	00900	HOUSEKEEPING	37,019	322,435	48,027	370,462	15,567	9.00
10.00	01000	DIETARY	36,568	305,200	45,460	350,660	14,735	10.00
11.00	01100	CAFETERIA	0	8,418	1,254	9,672	406	11.00
13.00	01300	NURSING ADMINISTRATION	23,873	187,214	27,886	215,100	9,039	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	11,165	98,758	14,710	113,468	4,768	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,075	328,984	49,002	377,986	15,883	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	298,567	44,472	343,039	14,414	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	165,946	1,741,556	259,407	2,000,963	84,080	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,380	386,942	57,635	444,577	18,681	50.00
53.00	05300	ANESTHESIOLOGY	0	285	42	327	14	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	76,754	959,329	142,893	1,102,222	46,315	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	11,244	138,968	20,699	159,667	6,709	54.01
56.00	05600	RADIOISOTOPE	6,712	126,357	18,821	145,178	6,100	56.00
58.00	05800	MRI	231	104,943	15,631	120,574	5,067	58.00
60.00	06000	LABORATORY	110,809	1,351,431	201,297	1,552,728	65,246	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	49,608	7,389	56,997	2,395	62.00
64.00	06400	INTRAVENOUS THERAPY	0	10,441	1,555	11,996	504	64.00
66.00	06600	PHYSICAL THERAPY	77,897	746,150	111,140	857,290	36,023	66.00
67.00	06700	OCCUPATIONAL THERAPY	25,606	200,928	29,928	230,856	9,701	67.00
68.00	06800	SPEECH PATHOLOGY	1,711	15,327	2,283	17,610	740	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	61,895	549,840	81,899	631,739	26,546	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	336,464	50,117	386,581	16,244	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,667	708,347	105,509	813,856	34,198	73.00
76.00	03020	OP SENIOR HEALTH	26,185	300,633	44,780	345,413	14,514	76.00
76.01	03550	TELEMEDICINE PSYCH	733	19,092	2,844	21,936	922	76.01
76.02	03950	DIABETIC EDUCATION	2,197	17,301	2,577	19,878	835	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	401,633	3,207,716	477,799	3,685,515	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	48,635	388,603	57,883	446,486	0	88.01
91.00	09100	EMERGENCY	146,766	2,066,979	307,879	2,374,858	99,787	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	56,793	561,594	83,650	645,244	27,113	95.00
101.00	10100	HOME HEALTH AGENCY	80,938	657,806	97,981	755,787	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,829,013	20,295,039	2,626,754	20,261,736	619,935	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,584	1,725	13,309	559	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,405	212,001	31,578	243,579	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	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)	1,850,418	20,518,624	2,660,057	20,518,624	620,494	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			6.00	7.00	7.01	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS	649,224					6.00
7.00	00700	OPERATION OF PLANT	54,532	372,165				7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	24,092			7.01
8.00	00800	LAUNDRY & LINEN SERVICE	15,837	13,136	0	113,990		8.00
9.00	00900	HOUSEKEEPING	2,401	1,991	0	0	390,421	9.00
10.00	01000	DIETARY	24,064	19,960	0	0	16,298	10.00
11.00	01100	CAFETERIA	10,941	9,075	0	0	7,410	11.00
13.00	01300	NURSING ADMINISTRATION	11,491	9,532	0	0	7,783	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	12,867	10,673	0	0	8,714	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,920	11,547	311	0	9,428	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	107,356	89,050	0	45,329	72,710	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	59,229	49,130	0	17,355	40,115	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,588	36,985	0	16,489	33,592	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	2,306	1,913	0	0	1,562	54.01
56.00	05600	RADIOISOTOPE	5,010	4,156	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	25,686	21,306	0	107	17,397	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	9,773	8,107	0	3,836	6,619	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,050	1,700	0	0	1,388	67.00
68.00	06800	SPEECH PATHOLOGY	1,480	1,228	0	0	1,003	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	46,173	38,300	0	2,655	31,272	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	7,287	6,045	0	0	4,936	73.00
76.00	03020	OP SENIOR HEALTH	7,430	6,163	1,303	0	5,032	76.00
76.01	03550	TELEMEDICINE PSYCH	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	128,117	0	22,478	718	86,770	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	59	0	88.01
91.00	09100	EMERGENCY	38,781	32,168	0	26,239	26,265	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	1,086	0	95.00
101.00	10100	HOME HEALTH AGENCY	15,125	0	0	65	10,244	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	646,444	372,165	24,092	113,938	388,538	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,780	0	0	0	1,883	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	52	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	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)	649,224	372,165	24,092	113,990	390,421	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	425,717					10.00
11.00	01100	CAFETERIA	336,139	373,643				11.00
13.00	01300	NURSING ADMINISTRATION	0	4,112	257,057			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,337	0	156,827		14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,323	0	0	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,015	60,105	124,952	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,161	11,266	25,209	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,180	0	2,521	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	3,183	0	42	0	54.01
56.00	05600	RADIOISOTOPE	0	1,521	0	13,723	0	56.00
58.00	05800	MRI	0	169	0	172	0	58.00
60.00	06000	LABORATORY	0	35,517	0	59,093	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	10,172	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2,141	0	64.00
66.00	06600	PHYSICAL THERAPY	0	18,533	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,746	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	225	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	21,096	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	68,963	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,816	0	0	0	73.00
76.00	03020	OP SENIOR HEALTH	22,746	9,182	20,558	0	0	76.00
76.01	03550	TELEMEDICINE PSYCH	0	310	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	479	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	83,762	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	656	60,387	41,434	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	44,904	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	425,717	371,249	257,057	156,827	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,394	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	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)	425,717	373,643	257,057	156,827	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	440,398					16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	357,453				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,950	0	2,673,510	0	2,673,510	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,669	0	681,392	0	681,392	50.00
53.00	05300	ANESTHESIOLOGY	9,311	357,453	367,105	0	367,105	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	66,703	0	1,376,595	0	1,376,595	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	7,746	0	183,128	0	183,128	54.01
56.00	05600	RADIOISOTOPE	6,636	0	182,324	0	182,324	56.00
58.00	05800	MRI	12,689	0	138,671	0	138,671	58.00
60.00	06000	LABORATORY	85,100	0	1,862,180	0	1,862,180	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,086	0	70,650	0	70,650	62.00
64.00	06400	INTRAVENOUS THERAPY	6,381	0	21,022	0	21,022	64.00
66.00	06600	PHYSICAL THERAPY	19,985	0	960,166	0	960,166	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,730	0	259,171	0	259,171	67.00
68.00	06800	SPEECH PATHOLOGY	145	0	22,431	0	22,431	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	22,880	0	820,661	0	820,661	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,612	0	482,400	0	482,400	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,622	0	890,760	0	890,760	73.00
76.00	03020	OP SENIOR HEALTH	8,725	0	441,066	0	441,066	76.00
76.01	03550	TELEMEDICINE PSYCH	678	0	23,846	0	23,846	76.01
76.02	03950	DIABETIC EDUCATION	296	0	21,488	0	21,488	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	39,067	0	4,046,427	0	4,046,427	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,277	0	449,822	0	449,822	88.01
91.00	09100	EMERGENCY	32,677	0	2,733,252	0	2,733,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	25,250	0	698,693	0	698,693	95.00
101.00	10100	HOME HEALTH AGENCY	21,183	0	847,308	0	847,308	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	440,398	357,453	20,254,068	0	20,254,068	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	18,531	0	18,531	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	246,025	0	246,025	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	440,398	357,453	20,518,624	0	20,518,624	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	0	52,434	3,484	73,932	27,522	5.01
5.02	00591	A&G HOSPITAL ONLY	0	2,575	4,291	4,389	2,106	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	26,793	550	11,703	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,891	0	4,349	3,089	8.00
9.00	00900	HOUSEKEEPING	0	946	0	2,570	0	9.00
10.00	01000	DIETARY	0	12,827	0	0	720	10.00
11.00	01100	CAFETERIA	0	5,453	0	2,965	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,316	0	6,365	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,859	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6,474	668	0	93,473	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,905	0	416,789	21,889	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	31,573	0	0	87,609	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	23,768	0	0	183,588	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	1,229	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	2,671	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	13,692	0	0	5,261	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	5,210	0	0	82,425	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,093	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	789	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	24,613	0	0	15,284	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,885	0	0	0	73.00
76.00	03020	OP SENIOR HEALTH	0	0	2,795	0	0	76.00
76.01	03550	TELEMEDICINE PSYCH	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	48,204	0	8,285	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	983	88.01
91.00	09100	EMERGENCY	0	20,672	0	0	1,218	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	77,025	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	5,691	0	6,498	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	260,668	65,683	523,062	616,975	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	11,584	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	202	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	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)	0	260,668	65,683	534,646	617,177	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE AND GENERAL	A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	
			2A	4.00	5.01	5.02	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	157,372	0	157,372			5.01
5.02	00591	A&G HOSPITAL ONLY	13,361	0	4,759	18,120		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	4,779	764	5,543	6.00
7.00	00700	OPERATION OF PLANT	39,046	0	2,338	374	466	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	177	28	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	15,329	0	626	100	135	8.00
9.00	00900	HOUSEKEEPING	3,516	0	2,841	455	20	9.00
10.00	01000	DIETARY	13,547	0	2,689	430	205	10.00
11.00	01100	CAFETERIA	8,418	0	74	12	93	11.00
13.00	01300	NURSING ADMINISTRATION	11,681	0	1,650	264	98	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,859	0	870	139	110	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	100,615	0	2,899	464	119	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	2,631	421	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	442,583	0	15,347	2,455	917	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	119,182	0	3,410	545	506	50.00
53.00	05300	ANESTHESIOLOGY	0	0	3	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	207,356	0	8,454	1,352	381	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	1,229	0	1,225	196	20	54.01
56.00	05600	RADIOISOTOPE	2,671	0	1,113	178	43	56.00
58.00	05800	MRI	0	0	925	148	0	58.00
60.00	06000	LABORATORY	18,953	0	11,909	1,905	219	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	437	70	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	92	15	0	64.00
66.00	06600	PHYSICAL THERAPY	87,635	0	6,575	1,052	83	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,093	0	1,771	283	17	67.00
68.00	06800	SPEECH PATHOLOGY	789	0	135	22	13	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	39,897	0	4,845	775	394	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	2,965	474	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,885	0	6,242	999	62	73.00
76.00	03020	OP SENIOR HEALTH	2,795	0	2,649	424	63	76.00
76.01	03550	TELEMEDICINE PSYCH	0	0	168	27	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	152	24	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	56,489	0	28,268	0	1,095	88.00
88.01	08801	RURAL HEALTH CLINIC II	983	0	3,424	0	0	88.01
91.00	09100	EMERGENCY	21,890	0	18,214	2,917	331	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	77,025	0	4,949	792	0	95.00
101.00	10100	HOME HEALTH AGENCY	12,189	0	5,797	0	129	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,466,388	0	155,402	18,104	5,519	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,584	0	102	16	24	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	202	0	1,868	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	0	0	0	0	0	194.04
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,478,174	0	157,372	18,120	5,543	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	OPERATION OF PLANT	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	42,224					7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	205				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,490	0	17,680			8.00
9.00	00900	HOUSEKEEPING	226	0	0	7,058		9.00
10.00	01000	DIETARY	2,265	0	0	295	19,431	10.00
11.00	01100	CAFETERIA	1,030	0	0	134	15,343	11.00
13.00	01300	NURSING ADMINISTRATION	1,081	0	0	141	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,211	0	0	158	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,310	3	0	170	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,104	0	7,031	1,314	2,967	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,574	0	2,692	725	53	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,196	0	2,557	607	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	217	0	0	28	0	54.01
56.00	05600	RADIOISOTOPE	471	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,417	0	17	314	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	920	0	595	120	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	193	0	0	25	0	67.00
68.00	06800	SPEECH PATHOLOGY	139	0	0	18	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,345	0	412	565	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	686	0	0	89	0	73.00
76.00	03020	OP SENIOR HEALTH	699	11	0	91	1,038	76.00
76.01	03550	TELEMEDICINE PSYCH	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	191	111	1,570	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	9	0	0	88.01
91.00	09100	EMERGENCY	3,650	0	4,070	475	30	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	168	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	10	185	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,224	205	17,672	7,024	19,431	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	34	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	8	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	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)	42,224	205	17,680	7,058	19,431	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	25,104					11.00
13.00	01300	NURSING ADMINISTRATION	276	15,191				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	426	0	9,773			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	761	0	0	0	106,341	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,038	7,383	0	0	5,783	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	757	1,490	0	0	3,542	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	2,248	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,826	0	157	0	16,106	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	214	0	3	0	1,870	54.01
56.00	05600	RADIOISOTOPE	102	0	855	0	1,602	56.00
58.00	05800	MRI	11	0	11	0	3,064	58.00
60.00	06000	LABORATORY	2,386	0	3,682	0	20,551	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	634	0	262	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	133	0	1,541	64.00
66.00	06600	PHYSICAL THERAPY	1,245	0	0	0	4,826	66.00
67.00	06700	OCCUPATIONAL THERAPY	386	0	0	0	1,867	67.00
68.00	06800	SPEECH PATHOLOGY	15	0	0	0	35	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	1,417	0	0	0	5,525	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	4,298	0	2,562	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	727	0	0	0	3,289	73.00
76.00	03020	OP SENIOR HEALTH	617	1,215	0	0	2,107	76.00
76.01	03550	TELEMEDICINE PSYCH	21	0	0	0	164	76.01
76.02	03950	DIABETIC EDUCATION	32	0	0	0	71	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,629	0	0	0	9,433	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	791	88.01
91.00	09100	EMERGENCY	4,057	2,449	0	0	7,890	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	6,097	95.00
101.00	10100	HOME HEALTH AGENCY	0	2,654	0	0	5,115	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	24,943	15,191	9,773	0	106,341	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	161	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	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)	25,104	15,191	9,773	0	106,341	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	3,052					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		499,922	0	499,922		30.00
31.00	03100	INTENSIVE CARE UNIT		0	0	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		138,476	0	138,476		50.00
53.00	05300	ANESTHESIOLOGY		2,251	0	2,251		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		242,992	0	242,992		54.00
54.01	05401	RADIOLOGY-ULTRASOUND		5,002	0	5,002		54.01
56.00	05600	RADIOISOTOPE		7,035	0	7,035		56.00
58.00	05800	MRI		4,159	0	4,159		58.00
60.00	06000	LABORATORY		62,353	0	62,353		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		1,403	0	1,403		62.00
64.00	06400	INTRAVENOUS THERAPY		1,781	0	1,781		64.00
66.00	06600	PHYSICAL THERAPY		103,051	0	103,051		66.00
67.00	06700	OCCUPATIONAL THERAPY		5,635	0	5,635		67.00
68.00	06800	SPEECH PATHOLOGY		1,166	0	1,166		68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0		69.00
69.01	03160	CARDIOPULMONARY		58,175	0	58,175		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		10,299	0	10,299		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		15,979	0	15,979		73.00
76.00	03020	OP SENIOR HEALTH		11,709	0	11,709		76.00
76.01	03550	TELEMEDICINE PSYCH		380	0	380		76.01
76.02	03950	DIABETIC EDUCATION		279	0	279		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		102,786	0	102,786		88.00
88.01	08801	RURAL HEALTH CLINIC II		5,207	0	5,207		88.01
91.00	09100	EMERGENCY		65,973	0	65,973		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE		0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES		89,031	0	89,031		95.00
101.00	10100	HOME HEALTH AGENCY		26,079	0	26,079		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,461,123	0	1,461,123		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		11,760	0	11,760		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		2,239	0	2,239		192.00
194.00	07950	HOSPICE		0	0	0		194.00
194.01	07951	FAMILY MEDICAL CENTER		0	0	0		194.01
194.02	07952	MEALS ON WHEELS		0	0	0		194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS		0	0	0		194.04
200.00		Cross Foot Adjustments	3,052	3,052	0	3,052		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	3,052	1,478,174	0	1,478,174		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	51,535					1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING	0	18,398				1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG	0	0	13,523			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				613,173		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	10,775,716	4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	10,367	976	1,870	27,343	1,209,677	5.01
5.02	00591	A&G HOSPITAL ONLY	509	1,202	111	2,092	291,346	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	257,168	6.00
7.00	00700	OPERATION OF PLANT	5,297	154	296	0	0	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,560	0	110	3,069	32,976	8.00
9.00	00900	HOUSEKEEPING	187	0	65	0	215,576	9.00
10.00	01000	DIETARY	2,536	0	0	715	212,948	10.00
11.00	01100	CAFETERIA	1,078	0	75	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,051	0	161	0	139,022	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,356	0	0	0	65,019	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,280	187	0	92,867	146,023	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	772	0	10,542	21,747	966,367	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,242	0	0	87,041	217,678	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,699	0	0	182,397	446,968	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	0	65,480	54.01
56.00	05600	RADIOISOTOPE	528	0	0	0	39,088	56.00
58.00	05800	MRI	0	0	0	0	1,348	58.00
60.00	06000	LABORATORY	2,707	0	0	5,227	645,284	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	0	81,890	453,627	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	0	149,113	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	0	9,963	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,866	0	0	15,185	360,437	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	768	0	0	0	277,582	73.00
76.00	03020	OP SENIOR HEALTH	0	783	0	0	152,487	76.00
76.01	03550	TELEMEDICINE PSYCH	0	0	0	0	4,269	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	12,796	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,502	0	8,231	2,338,869	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	977	283,220	88.01
91.00	09100	EMERGENCY	4,087	0	0	1,210	854,676	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	76,525	330,729	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,594	0	6,456	471,332	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,535	18,398	13,230	612,972	10,651,068	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	293	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	201	124,648	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	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)	260,668	65,683	534,646	617,177	1,850,418	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.058077	3.570116	39.536050	1.006530	0.171721	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					0	204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/10/2016 3:52 pm

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	
		1.00	1.01	1.02	2.00	4.00	
205.00	Unit cost multiplier (Wkst. B, Part II)					0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5A.01	5.01	5A.02	5.02	6.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL	-2,660,057	17,858,567				5.01
5.02	00591	A&G HOSPITAL ONLY	0	540,053	-620,494	14,766,763		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	542,272	0	623,044	68,420	6.00
7.00	00700	OPERATION OF PLANT	0	265,306	0	304,824	5,747	7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	20,123	0	23,120	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	71,012	0	81,589	1,669	8.00
9.00	00900	HOUSEKEEPING	0	322,435	0	370,462	253	9.00
10.00	01000	DIETARY	0	305,200	0	350,660	2,536	10.00
11.00	01100	CAFETERIA	0	8,418	0	9,672	1,153	11.00
13.00	01300	NURSING ADMINISTRATION	0	187,214	0	215,100	1,211	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	98,758	0	113,468	1,356	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	328,984	0	377,986	1,467	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	298,567	0	343,039	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,741,556	0	2,000,963	11,314	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	386,942	0	444,577	6,242	50.00
53.00	05300	ANESTHESIOLOGY	0	285	0	327	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	959,329	0	1,102,222	4,699	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	138,968	0	159,667	243	54.01
56.00	05600	RADIOISOTOPE	0	126,357	0	145,178	528	56.00
58.00	05800	MRI	0	104,943	0	120,574	0	58.00
60.00	06000	LABORATORY	0	1,351,431	0	1,552,728	2,707	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	49,608	0	56,997	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	10,441	0	11,996	0	64.00
66.00	06600	PHYSICAL THERAPY	0	746,150	0	857,290	1,030	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	200,928	0	230,856	216	67.00
68.00	06800	SPEECH PATHOLOGY	0	15,327	0	17,610	156	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0	549,840	0	631,739	4,866	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	336,464	0	386,581	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	708,347	0	813,856	768	73.00
76.00	03020	OP SENIOR HEALTH	0	300,633	0	345,413	783	76.00
76.01	03550	TELEMEDICINE PSYCH	0	19,092	0	21,936	0	76.01
76.02	03950	DIABETIC EDUCATION	0	17,301	0	19,878	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,207,716	-3,685,515	0	13,502	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	388,603	-446,486	0	0	88.01
91.00	09100	EMERGENCY	0	2,066,979	0	2,374,858	4,087	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	561,594	0	645,244	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	657,806	-755,787	0	1,594	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,660,057	17,634,982	-5,508,282	14,753,454	68,127	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,584	0	13,309	293	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	212,001	-243,579	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	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)		2,660,057		620,494	649,224	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.148951		0.042020	9.488804	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		157,372		18,120	5,543	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.008812		0.001227	0.081014	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			7.00	7.01	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT	47,284					7.00
7.01	00701	OPERATION OF PLANT-CLINIC	0	14,472				7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,669	0	56,494			8.00
9.00	00900	HOUSEKEEPING	253	0	0	60,751		9.00
10.00	01000	DIETARY	2,536	0	0	2,536	31,162	10.00
11.00	01100	CAFETERIA	1,153	0	0	1,153	24,605	11.00
13.00	01300	NURSING ADMINISTRATION	1,211	0	0	1,211	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,356	0	0	1,356	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,467	187	0	1,467	0	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,314	0	22,466	11,314	4,759	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,242	0	8,601	6,242	85	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,699	0	8,172	5,227	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	243	0	0	243	0	54.01
56.00	05600	RADIOISOTOPE	528	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	2,707	0	53	2,707	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	1,030	0	1,901	1,030	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	216	0	0	216	0	67.00
68.00	06800	SPEECH PATHOLOGY	156	0	0	156	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	4,866	0	1,316	4,866	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	768	0	0	768	0	73.00
76.00	03020	OP SENIOR HEALTH	783	783	0	783	1,665	76.00
76.01	03550	TELEMEDICINE PSYCH	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	13,502	356	13,502	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	29	0	0	88.01
91.00	09100	EMERGENCY	4,087	0	13,004	4,087	48	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	538	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	0	32	1,594	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,284	14,472	56,468	60,458	31,162	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	293	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	26	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	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)	372,165	24,092	113,990	390,421	425,717	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.870844	1.664732	2.017736	6.426577	13.661415	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	42,224	205	17,680	7,058	19,431	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.892987	0.014165	0.312954	0.116179	0.623548	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING						1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	ADMINISTRATIVE AND GENERAL						5.01
5.02	00591	A&G HOSPITAL ONLY						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-CLINIC						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	13,266					11.00
13.00	01300	NURSING ADMINISTRATION	146	84,890				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	225	0	764,804			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	402	0	0	0	34,193,436	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,134	41,264	0	0	1,859,453	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	400	8,325	0	0	1,138,923	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	722,882	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	965	0	12,293	0	5,178,783	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	113	0	203	0	601,360	54.01
56.00	05600	RADIOISOTOPE	54	0	66,925	0	515,191	56.00
58.00	05800	MRI	6	0	837	0	985,194	58.00
60.00	06000	LABORATORY	1,261	0	288,180	0	6,608,290	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	49,608	0	84,288	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	10,441	0	495,393	64.00
66.00	06600	PHYSICAL THERAPY	658	0	0	0	1,551,636	66.00
67.00	06700	OCCUPATIONAL THERAPY	204	0	0	0	600,174	67.00
68.00	06800	SPEECH PATHOLOGY	8	0	0	0	11,258	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	749	0	0	0	1,776,424	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	336,317	0	823,889	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	384	0	0	0	1,057,622	73.00
76.00	03020	OP SENIOR HEALTH	326	6,789	0	0	677,379	76.00
76.01	03550	TELEMEDICINE PSYCH	11	0	0	0	52,618	76.01
76.02	03950	DIABETIC EDUCATION	17	0	0	0	22,950	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,974	0	0	0	3,033,153	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	254,422	88.01
91.00	09100	EMERGENCY	2,144	13,683	0	0	2,537,058	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	1,960,437	95.00
101.00	10100	HOME HEALTH AGENCY	0	14,829	0	0	1,644,659	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,181	84,890	764,804	0	34,193,436	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	85	0	0	0	0	192.00
194.00	07950	HOSPICE	0	0	0	0	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	0	0	0	0	194.01
194.02	07952	MEALS ON WHEELS	0	0	0	0	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	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)	373,643	257,057	156,827	0	440,398	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	28.165461	3.028119	0.205055	0.000000	0.012880	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	25,104	15,191	9,773	0	106,341	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.892356	0.178949	0.012778	0.000000	0.003110	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/10/2016 3:52 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-CLINIC BUILDING		1.01
1.02	00102	NEW CAP REL COSTS-NEW MED SURG		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.01	00590	ADMINISTRATIVE AND GENERAL		5.01
5.02	00591	A&G HOSPITAL ONLY		5.02
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
7.01	00701	OPERATION OF PLANT-CLINIC		7.01
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	100	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	54.01
56.00	05600	RADIOISOTOPE	0	56.00
58.00	05800	MRI	0	58.00
60.00	06000	LABORATORY	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	64.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
69.01	03160	CARDIOPULMONARY	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03020	OP SENIOR HEALTH	0	76.00
76.01	03550	TELEMEDICINE PSYCH	0	76.01
76.02	03950	DIABETIC EDUCATION	0	76.02
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	88.01
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0	95.00
101.00	10100	HOME HEALTH AGENCY	0	101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
194.00	07950	HOSPICE	0	194.00
194.01	07951	FAMILY MEDICAL CENTER	0	194.01
194.02	07952	MEALS ON WHEELS	0	194.02
194.04	07953	OTHER NONREIMBURSABLE COST AREAS	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)	357,453	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,574.530000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,052	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	30.520000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,673,510		2,673,510	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	681,392		681,392	0	0	50.00
53.00	05300	ANESTHESIOLOGY	367,105		367,105	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,376,595		1,376,595	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	183,128		183,128	0	0	54.01
56.00	05600	RADIOISOTOPE	182,324		182,324	0	0	56.00
58.00	05800	MRI	138,671		138,671	0	0	58.00
60.00	06000	LABORATORY	1,862,180		1,862,180	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	70,650		70,650	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	21,022		21,022	0	0	64.00
66.00	06600	PHYSICAL THERAPY	960,166	0	960,166	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	259,171	0	259,171	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	22,431	0	22,431	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	820,661		820,661	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	482,400		482,400	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	890,760		890,760	0	0	73.00
76.00	03020	OP SENIOR HEALTH	441,066		441,066	0	0	76.00
76.01	03550	TELEMEDICINE PSYCH	23,846		23,846	0	0	76.01
76.02	03950	DIABETIC EDUCATION	21,488		21,488	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,046,427		4,046,427	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	449,822		449,822	0	0	88.01
91.00	09100	EMERGENCY	2,733,252		2,733,252	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	269,812		269,812		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	698,693		698,693	0	0	95.00
101.00	10100	HOME HEALTH AGENCY	847,308		847,308		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,523,880	0	20,523,880	0	0	200.00
201.00		Less Observation Beds	269,812		269,812		0	201.00
202.00		Total (see instructions)	20,254,068	0	20,254,068	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,500,307		1,500,307			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	74,711	1,064,212	1,138,923	0.598277	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	46,991	675,891	722,882	0.507835	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	217,467	4,961,316	5,178,783	0.265814	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	41,100	560,260	601,360	0.304523	0.000000	54.01
56.00	05600	RADIOISOTOPE	10,784	504,407	515,191	0.353896	0.000000	56.00
58.00	05800	MRI	29,965	955,229	985,194	0.140755	0.000000	58.00
60.00	06000	LABORATORY	633,841	5,974,449	6,608,290	0.281795	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	37,945	46,343	84,288	0.838198	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	28,189	467,204	495,393	0.042435	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	244,529	1,307,107	1,551,636	0.618809	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	227,026	373,148	600,174	0.431826	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	9,888	1,370	11,258	1.992450	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	284,377	1,492,047	1,776,424	0.461974	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	287,324	536,565	823,889	0.585516	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	307,500	750,122	1,057,622	0.842229	0.000000	73.00
76.00	03020	OP SENIOR HEALTH	0	677,379	677,379	0.651136	0.000000	76.00
76.01	03550	TELEMEDICINE PSYCH	0	52,618	52,618	0.453191	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0	22,950	22,950	0.936296	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,033,153	3,033,153			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	254,422	254,422			88.01
91.00	09100	EMERGENCY	13,275	2,523,783	2,537,058	1.077331	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	359,146	359,146	0.751260	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	744	1,959,693	1,960,437	0.356397	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,644,659	1,644,659			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,995,963	30,197,473	34,193,436			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,995,963	30,197,473	34,193,436			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
		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
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000	54.01
56.00	05600	RADIOISOTOPE	0.000000	56.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
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
69.01	03160	CARDIOPULMONARY	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03020	OP SENIOR HEALTH	0.000000	76.00
76.01	03550	TELEMEDICINE PSYCH	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/10/2016 3:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,673,510		2,673,510	0	2,673,510	30.00
31.00	03100	INTENSIVE CARE UNIT	0		0	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	681,392		681,392	0	681,392	50.00
53.00	05300	ANESTHESIOLOGY	367,105		367,105	0	367,105	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,376,595		1,376,595	0	1,376,595	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	183,128		183,128	0	183,128	54.01
56.00	05600	RADIOISOTOPE	182,324		182,324	0	182,324	56.00
58.00	05800	MRI	138,671		138,671	0	138,671	58.00
60.00	06000	LABORATORY	1,862,180		1,862,180	0	1,862,180	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	70,650		70,650	0	70,650	62.00
64.00	06400	INTRAVENOUS THERAPY	21,022		21,022	0	21,022	64.00
66.00	06600	PHYSICAL THERAPY	960,166	0	960,166	0	960,166	66.00
67.00	06700	OCCUPATIONAL THERAPY	259,171	0	259,171	0	259,171	67.00
68.00	06800	SPEECH PATHOLOGY	22,431	0	22,431	0	22,431	68.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	69.00
69.01	03160	CARDIOPULMONARY	820,661		820,661	0	820,661	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	482,400		482,400	0	482,400	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	890,760		890,760	0	890,760	73.00
76.00	03020	OP SENIOR HEALTH	441,066		441,066	0	441,066	76.00
76.01	03550	TELEMEDICINE PSYCH	23,846		23,846	0	23,846	76.01
76.02	03950	DIABETIC EDUCATION	21,488		21,488	0	21,488	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,046,427		4,046,427	0	4,046,427	88.00
88.01	08801	RURAL HEALTH CLINIC II	449,822		449,822	0	449,822	88.01
91.00	09100	EMERGENCY	2,733,252		2,733,252	0	2,733,252	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	269,812		269,812		269,812	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	698,693		698,693	0	698,693	95.00
101.00	10100	HOME HEALTH AGENCY	847,308		847,308		847,308	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	20,523,880	0	20,523,880	0	20,523,880	200.00
201.00		Less Observation Beds	269,812		269,812		269,812	201.00
202.00		Total (see instructions)	20,254,068	0	20,254,068	0	20,254,068	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/10/2016 3:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,500,307		1,500,307			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	74,711	1,064,212	1,138,923	0.598277	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	46,991	675,891	722,882	0.507835	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	217,467	4,961,316	5,178,783	0.265814	0.000000	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	41,100	560,260	601,360	0.304523	0.000000	54.01
56.00	05600	RADIOISOTOPE	10,784	504,407	515,191	0.353896	0.000000	56.00
58.00	05800	MRI	29,965	955,229	985,194	0.140755	0.000000	58.00
60.00	06000	LABORATORY	633,841	5,974,449	6,608,290	0.281795	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	37,945	46,343	84,288	0.838198	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	28,189	467,204	495,393	0.042435	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	244,529	1,307,107	1,551,636	0.618809	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	227,026	373,148	600,174	0.431826	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	9,888	1,370	11,258	1.992450	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
69.01	03160	CARDIOPULMONARY	284,377	1,492,047	1,776,424	0.461974	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	287,324	536,565	823,889	0.585516	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	307,500	750,122	1,057,622	0.842229	0.000000	73.00
76.00	03020	OP SENIOR HEALTH	0	677,379	677,379	0.651136	0.000000	76.00
76.01	03550	TELEMEDICINE PSYCH	0	52,618	52,618	0.453191	0.000000	76.01
76.02	03950	DIABETIC EDUCATION	0	22,950	22,950	0.936296	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,033,153	3,033,153	1.334066	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	254,422	254,422	1.768015	0.000000	88.01
91.00	09100	EMERGENCY	13,275	2,523,783	2,537,058	1.077331	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	359,146	359,146	0.751260	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	744	1,959,693	1,960,437	0.356397	0.000000	95.00
101.00	10100	HOME HEALTH AGENCY	0	1,644,659	1,644,659			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	3,995,963	30,197,473	34,193,436			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,995,963	30,197,473	34,193,436			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/10/2016 3:52 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.000000		54.01
56.00	05600	RADIOISOTOPE	0.000000		56.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
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
69.01	03160	CARDIOPULMONARY	0.000000		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	OP SENIOR HEALTH	0.000000		76.00
76.01	03550	TELEMEDICINE PSYCH	0.000000		76.01
76.02	03950	DIABETIC EDUCATION	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		88.01
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	138,476	1,138,923	0.121585	42,270	5,139	50.00
53.00	05300	ANESTHESIOLOGY	2,251	722,882	0.003114	28,009	87	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	242,992	5,178,783	0.046921	119,971	5,629	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	5,002	601,360	0.008318	18,568	154	54.01
56.00	05600	RADIOISOTOPE	7,035	515,191	0.013655	10,784	147	56.00
58.00	05800	MRI	4,159	985,194	0.004222	26,585	112	58.00
60.00	06000	LABORATORY	62,353	6,608,290	0.009436	313,358	2,957	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,403	84,288	0.016645	29,766	495	62.00
64.00	06400	INTRAVENOUS THERAPY	1,781	495,393	0.003595	10,337	37	64.00
66.00	06600	PHYSICAL THERAPY	103,051	1,551,636	0.066414	60,092	3,991	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,635	600,174	0.009389	53,325	501	67.00
68.00	06800	SPEECH PATHOLOGY	1,166	11,258	0.103571	1,882	195	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	58,175	1,776,424	0.032748	136,646	4,475	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,299	823,889	0.012500	147,411	1,843	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,979	1,057,622	0.015108	125,724	1,899	73.00
76.00	03020	OP SENIOR HEALTH	11,709	677,379	0.017286	0	0	76.00
76.01	03550	TELEMEDICINE PSYCH	380	52,618	0.007222	0	0	76.01
76.02	03950	DIABETIC EDUCATION	279	22,950	0.012157	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	102,786	3,033,153	0.033888	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	5,207	254,422	0.020466	0	0	88.01
91.00	09100	EMERGENCY	65,973	2,537,058	0.026004	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	79,009	359,146	0.219991	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	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)	925,100	29,088,033		1,124,728	27,661	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	357,453	0	0	0	357,453	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
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
69.01	03160	CARDIOPULMONARY	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	OP SENIOR HEALTH	0	0	0	0	0	76.00
76.01	03550	TELEMEDICINE PSYCH	0	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	357,453	0	0	0	357,453	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,138,923	0.000000	0.000000	42,270	50.00
53.00	05300	ANESTHESIOLOGY	0	722,882	0.494483	0.000000	28,009	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,178,783	0.000000	0.000000	119,971	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	601,360	0.000000	0.000000	18,568	54.01
56.00	05600	RADIOISOTOPE	0	515,191	0.000000	0.000000	10,784	56.00
58.00	05800	MRI	0	985,194	0.000000	0.000000	26,585	58.00
60.00	06000	LABORATORY	0	6,608,290	0.000000	0.000000	313,358	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	84,288	0.000000	0.000000	29,766	62.00
64.00	06400	INTRAVENOUS THERAPY	0	495,393	0.000000	0.000000	10,337	64.00
66.00	06600	PHYSICAL THERAPY	0	1,551,636	0.000000	0.000000	60,092	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	600,174	0.000000	0.000000	53,325	67.00
68.00	06800	SPEECH PATHOLOGY	0	11,258	0.000000	0.000000	1,882	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
69.01	03160	CARDIOPULMONARY	0	1,776,424	0.000000	0.000000	136,646	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	823,889	0.000000	0.000000	147,411	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,057,622	0.000000	0.000000	125,724	73.00
76.00	03020	OP SENIOR HEALTH	0	677,379	0.000000	0.000000	0	76.00
76.01	03550	TELEMEDICINE PSYCH	0	52,618	0.000000	0.000000	0	76.01
76.02	03950	DIABETIC EDUCATION	0	22,950	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,033,153	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	254,422	0.000000	0.000000	0	88.01
91.00	09100	EMERGENCY	0	2,537,058	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	359,146	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	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	29,088,033			1,124,728	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	13,850	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0	0		56.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
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
69.01	03160	CARDIOPULMONARY	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	OP SENIOR HEALTH	0	0	0		76.00
76.01	03550	TELEMEDICINE PSYCH	0	0	0		76.01
76.02	03950	DIABETIC EDUCATION	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	13,850	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.598277	0	481,573	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.507835	0	312,426	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265814	0	1,950,101	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.304523	0	236,158	0	0	54.01
56.00	05600	RADIOISOTOPE	0.353896	0	240,300	0	0	56.00
58.00	05800	MRI	0.140755	0	352,377	0	0	58.00
60.00	06000	LABORATORY	0.281795	0	2,845,474	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.838198	0	20,966	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.042435	0	200,257	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.618809	0	536,699	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.431826	0	54,734	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.992450	0	948	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.461974	0	684,821	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.585516	0	204,953	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.842229	0	466,848	0	0	73.00
76.00	03020	OP SENIOR HEALTH	0.651136	0	651,183	0	0	76.00
76.01	03550	TELEMEDICINE PSYCH	0.453191	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0.936296	0	10,070	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	1.077331	0	847,166	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.751260	0	71,782	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.356397		0			95.00
200.00		Subtotal (see instructions)		0	10,168,836	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	10,168,836	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	288,114	0		50.00
53.00	05300	ANESTHESIOLOGY	158,661	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	518,364	0		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	71,916	0		54.01
56.00	05600	RADIOISOTOPE	85,041	0		56.00
58.00	05800	MRI	49,599	0		58.00
60.00	06000	LABORATORY	801,840	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	17,574	0		62.00
64.00	06400	INTRAVENOUS THERAPY	8,498	0		64.00
66.00	06600	PHYSICAL THERAPY	332,114	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	23,636	0		67.00
68.00	06800	SPEECH PATHOLOGY	1,889	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	03160	CARDIOPULMONARY	316,369	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	120,003	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	393,193	0		73.00
76.00	03020	OP SENIOR HEALTH	424,009	0		76.00
76.01	03550	TELEMEDICINE PSYCH	0	0		76.01
76.02	03950	DIABETIC EDUCATION	9,429	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	912,678	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	53,927	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	4,586,854	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,586,854	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141313 | Component CCN: 14Z313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.598277	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.507835	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265814	0	0	0	0	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.304523	0	0	0	0	54.01
56.00	05600	RADIOISOTOPE	0.353896	0	0	0	0	56.00
58.00	05800	MRI	0.140755	0	0	0	0	58.00
60.00	06000	LABORATORY	0.281795	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.838198	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.042435	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.618809	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.431826	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.992450	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.461974	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.585516	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.842229	0	0	0	0	73.00
76.00	03020	OP SENIOR HEALTH	0.651136	0	0	0	0	76.00
76.01	03550	TELEMEDICINE PSYCH	0.453191	0	0	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0.936296	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
91.00	09100	EMERGENCY	1.077331	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.751260	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.356397		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: 141313 | Component CCN: 14Z313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V | Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0	0		54.01
56.00	05600	RADIOISOTOPE	0	0		56.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
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
69.01	03160	CARDIOPULMONARY	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	OP SENIOR HEALTH	0	0		76.00
76.01	03550	TELEMEDICINE PSYCH	0	0		76.01
76.02	03950	DIABETIC EDUCATION	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	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: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,148	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	715	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.	24	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	578	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	101	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)	302	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	8	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)	22	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	401	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)	94	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)	281	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)	16	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,673,510	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)	1,076	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)	2,960	25.00
26.00	Total swing-bed cost (see instructions)	966,287	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,707,223	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	910,777	28.00
29.00	Private room charges (excluding swing-bed charges)	48,889	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	861,888	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	1.874469	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	2,037.04	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1,491.16	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	545.88	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	1,023.24	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	24,558	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,682,665	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)	2,353.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	943,705	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	16,372	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	960,077	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	517,595	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,477,672	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)	221,218	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	661,300	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	882,518	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)	113	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,387.72	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	269,812	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	499,922	1,707,223	0.292828	269,812	79,009	90.00
91.00	Nursing School cost	0	1,707,223	0.000000	269,812	0	91.00
92.00	Allied health cost	0	1,707,223	0.000000	269,812	0	92.00
93.00	All other Medical Education	0	1,707,223	0.000000	269,812	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		686,255		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.598277	42,270	25,289	50.00
53.00	05300	ANESTHESIOLOGY	0.507835	28,009	14,224	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265814	119,971	31,890	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.304523	18,568	5,654	54.01
56.00	05600	RADIOISOTOPE	0.353896	10,784	3,816	56.00
58.00	05800	MRI	0.140755	26,585	3,742	58.00
60.00	06000	LABORATORY	0.281795	313,358	88,303	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.838198	29,766	24,950	62.00
64.00	06400	INTRAVENOUS THERAPY	0.042435	10,337	439	64.00
66.00	06600	PHYSICAL THERAPY	0.618809	60,092	37,185	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.431826	53,325	23,027	67.00
68.00	06800	SPEECH PATHOLOGY	1.992450	1,882	3,750	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.461974	136,646	63,127	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.585516	147,411	86,311	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.842229	125,724	105,888	73.00
76.00	03020	OP SENIOR HEALTH	0.651136	0	0	76.00
76.01	03550	TELEMEDICINE PSYCH	0.453191	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0.936296	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	1.077331	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.751260	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	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)		1,124,728	517,595	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)		1,124,728		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141313 | Component CCN: 14Z313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.598277	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.507835	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.265814	23,176	6,161	54.00
54.01	05401	RADIOLOGY-ULTRASOUND	0.304523	834	254	54.01
56.00	05600	RADIOISOTOPE	0.353896	0	0	56.00
58.00	05800	MRI	0.140755	0	0	58.00
60.00	06000	LABORATORY	0.281795	122,159	34,424	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.838198	2,933	2,458	62.00
64.00	06400	INTRAVENOUS THERAPY	0.042435	6,451	274	64.00
66.00	06600	PHYSICAL THERAPY	0.618809	130,048	80,475	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.431826	129,043	55,724	67.00
68.00	06800	SPEECH PATHOLOGY	1.992450	7,795	15,531	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	69.00
69.01	03160	CARDIOPULMONARY	0.461974	88,444	40,859	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.585516	57,337	33,572	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.842229	81,746	68,849	73.00
76.00	03020	OP SENIOR HEALTH	0.651136	0	0	76.00
76.01	03550	TELEMEDICINE PSYCH	0.453191	0	0	76.01
76.02	03950	DIABETIC EDUCATION	0.936296	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
91.00	09100	EMERGENCY	1.077331	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.751260	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTE	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)		649,966	338,581	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)		649,966		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141313	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/10/2016 3:52 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,586,854	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)	4,586,854	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)	4,632,723	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)	31,729	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,466,977	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)	3,134,017	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)	3,134,017	30.00
31.00	Primary payer payments	272	31.00
32.00	Subtotal (line 30 minus line 31)	3,133,745	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)	285,299	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	185,444	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	224,862	36.00
37.00	Subtotal (see instructions)	3,319,189	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,319,189	40.00
40.01	Sequestration adjustment (see instructions)	66,384	40.01
41.00	Interim payments	3,504,262	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-251,457	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: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,136,343		3,453,762	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	04/21/2015	115,200	04/21/2015	50,500	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)		115,200		50,500	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)		1,251,543		3,504,262	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		101,776		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		251,457	6.02
7.00	Total Medicare program liability (see instructions)		1,353,319		3,252,805	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: 141313 | Component CCN: 14Z313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/10/2016 3:52 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		990,896		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	04/21/2015	93,900		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)		93,900		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)		1,084,796		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		117,419		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,202,215		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: 141313	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/10/2016 3:52 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	224	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	401	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	79	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	602	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	34,193,436	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	80,981	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	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)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141313 Component CCN: 14Z313	Period: From 10/01/2014 To 09/30/2015	Worksheet E-2 Date/Time Prepared: 2/10/2016 3:52 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	891,343	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)	341,967	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	375	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)	1,233,310	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,233,310	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)	1,233,310	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	6,560	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)	1,226,750	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,226,750	0	19.00
19.01	Sequestration adjustment (see instructions)	24,535	0	19.01
20.00	Interim payments	1,084,796	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)	117,419	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: 141313	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part V Date/Time Prepared: 2/10/2016 3:52 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,477,672	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)	1,477,672	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,492,449	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,492,449	19.00
20.00	Deductibles (exclude professional component)	135,800	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,356,649	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,356,649	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	37,368	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	24,289	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	29,624	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,380,938	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,380,938	30.00
30.01	Sequestration adjustment (see instructions)	27,619	30.01
31.00	Interim payments	1,251,543	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)	101,776	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: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/10/2016 3:52 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,507,617	0	0	0	1.00
2.00	Temporary investments	512,548	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	3,852,736	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	451,424	0	0	0	7.00
8.00	Prepaid expenses	136,426	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)	9,460,751	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	10,330,786	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	10,330,786	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,291,165	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,707,485	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,998,650	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	23,790,187	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	658,760	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,362,210	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	735,985	0	0	0	40.00
41.00	Deferred income	642,000	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	604,442	0	0	0	43.00
44.00	Other current liabilities	318,793	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,322,190	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,364,894	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	2,904,219	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	9,269,113	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	13,591,303	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	10,198,884				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)	10,198,884	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	23,790,187	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 2/10/2016 3:52 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		8,875,871		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,055,271				2.00
3.00	Total (sum of line 1 and line 2)		9,931,142		0		3.00
4.00	PY ADJUSTMENT	267,742		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)		267,742		0		10.00
11.00	Subtotal (line 3 plus line 10)		10,198,884		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,198,884		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	PY ADJUSTMENT		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II | Date/Time Prepared: 2/10/2016 3:52 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,862,233		1,862,233	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,862,233		1,862,233	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	0		0	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)	1,862,233		1,862,233	17.00
18.00	Ancillary services	1	1	2	18.00
19.00	Outpatient services	0	1	1	19.00
20.00	RURAL HEALTH CLINIC	0	3,033,153	3,033,153	20.00
20.01	RURAL HEALTH CLINIC II	0	254,422	254,422	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		1,644,659	1,644,659	22.00
23.00	AMBULANCE SERVICES	744	1,966,670	1,967,414	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OPERATING ROOM	128,631	1,271,140	1,399,771	27.00
27.01	ANESTHESIOLOGY	53,580	780,983	834,563	27.01
27.02	RADIOLOGY-DIAGNOSTIC	222,939	5,135,029	5,357,968	27.02
27.03	RADIOLOGY-ULTRASOUND	41,100	574,813	615,913	27.03
27.04	RADIOISOTOPE	10,784	539,169	549,953	27.04
27.05	MRI	29,965	991,007	1,020,972	27.05
27.06	LABORATORY	672,456	6,148,562	6,821,018	27.06
27.07	INTRAVENOUS THERAPY	53,511	485,441	538,952	27.07
27.08	PHYSICAL THERAPY	244,529	1,325,499	1,570,028	27.08
27.09	OCCUPATIONAL THERAPY	227,080	377,084	604,164	27.09
27.10	SPEECH PATHOLOGY	9,388	1,870	11,258	27.10
27.11	CARDIOPULMONARY	453,632	1,687,818	2,141,450	27.11
27.12	MEDICAL SUPPLIES CHARGED	44,856	205,180	250,036	27.12
27.13	DRUGS CHARGED TO PATIENTS	307,500	770,602	1,078,102	27.13
27.14	OP SENIOR PSYCH	0	677,379	677,379	27.14
27.16	TELEMEDICINE PSYCH	0	52,618	52,618	27.16
27.17	DIABETIC PROGRAM	0	22,950	22,950	27.17
27.18	EMERGENCY	27,088	5,110,910	5,137,998	27.18
27.21	FITNESS CENTER	0	5,080	5,080	27.21
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	4,390,017	33,062,040	37,452,057	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		21,953,053		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	CONTRIBUTION EXP	0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00	EMPLOYEE PHYSICALS	4,814			38.00
39.00	PBA - PRIOR PERIOD SUPPLY COST BOOKE	5,893			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		10,707		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		21,942,346		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-3 | Date/Time Prepared: 2/10/2016 3:52 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	37,452,057	1.00
2.00	Less contractual allowances and discounts on patients' accounts	14,933,395	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,518,662	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	21,942,346	4.00
5.00	Net income from service to patients (line 3 minus line 4)	576,316	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	246,536	6.00
7.00	Income from investments	10,726	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	867,096	23.00
24.00	OTHER REVENUE	610,257	24.00
24.01	GRANT REVENUE	215,555	24.01
24.02	ELECTRONIC HEALTH RECORDS INCENTIVE	43,800	24.02
24.03	LAB OUTREACH REV	70	24.03
24.04	DIETARY CONSULTING	1,800	24.04
25.00	Total other income (sum of lines 6-24)	1,995,840	25.00
26.00	Total (line 5 plus line 25)	2,572,156	26.00
27.00	BAD DEBTS	1,411,159	27.00
27.01	CHARITY CARE	82,473	27.01
27.02	DIABETIC PROGRAM	22,950	27.02
27.03	ROUNDING	303	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	1,516,885	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,055,271	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141313 | HHA CCN: 147202 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H | Date/Time Prepared: 2/10/2016 3:52 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	139,480	9,486	34,826	0	29,766	213,558	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	317,486	21,592	0	0	0	339,078	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	14,366	977	0	0	0	15,343	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	471,332	32,055	34,826	0	29,766	567,979	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	213,558	-3,300	210,258			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	339,078	0	339,078			6.00
7.00	Physical Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	15,343	0	15,343			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	567,979	-3,300	564,679			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 141313 HHA CCN: 147202 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-1 Part I Date/Time Prepared: 2/10/2016 3:52 pm

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	210,258	0	0	0	0	210,258	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	339,078	0	0	0	0	339,078	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	15,343	0	0	0	0	15,343	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	564,679	0	0	0	0	564,679	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	210,258			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	201,156	540,234		6.00
7.00	Physical Therapy	0	0		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Home Health Aide	9,102	24,445		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
24.00	Total (sum of lines 1-23)		564,679		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 141313 HHA CCN: 147202 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-1 Part II Date/Time Prepared: 2/10/2016 3:52 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-210,258	354,421	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	339,078	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	15,343	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-210,258	354,421	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		210,258	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.593244	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141313 | HHA CCN: 147202 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part I | Date/Time Prepared: 2/10/2016 3:52 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	NEW CLINIC BUILDING	NEW NEW MED SURG	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	1.01	1.02	2.00	4.00	
1.00	Administrative and General	0	0	5,691	0	6,498	80,938	1.00
2.00	Skilled Nursing Care	540,234	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	24,445	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	564,679	0	5,691	0	6,498	80,938	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Subtotal	ADMINISTRATIVE AND GENERAL	Subtotal	A&G HOSPITAL ONLY	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		4A	5.01	5A.01	5.02	6.00	7.00	
1.00	Administrative and General	93,127	13,871	106,998	0	15,125	0	1.00
2.00	Skilled Nursing Care	540,234	80,469	620,703	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	24,445	3,641	28,086	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	657,806	97,981	755,787	0	15,125	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.000000		0.000000				21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141313 | HHA CCN: 147202 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part I | Date/Time Prepared: 2/10/2016 3:52 pm

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	Cost Center Description	OPERATION OF PLANT-CLINIC	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.01	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	65	10,244	0	0	44,904	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	65	10,244	0	0	44,904	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	19.00	24.00	25.00	
1.00	Administrative and General	0	0	21,183	0	198,519	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	620,703	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	28,086	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	21,183	0	847,308	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141313 | HHA CCN: 147202 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part I | Date/Time Prepared: 2/10/2016 3:52 pm

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	Cost Center Description	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		26.00	27.00	28.00			
1.00	Administrative and General	198,519					1.00
2.00	Skilled Nursing Care	620,703	189,925	810,628			2.00
3.00	Physical Therapy	0	0	0			3.00
4.00	Occupational Therapy	0	0	0			4.00
5.00	Speech Pathology	0	0	0			5.00
6.00	Medical Social Services	0	0	0			6.00
7.00	Home Health Aide	28,086	8,594	36,680			7.00
8.00	Supplies (see instructions)	0	0	0			8.00
9.00	Drugs	0	0	0			9.00
10.00	DME	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0			13.00
14.00	Clinic	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0			15.00
16.00	Day Care Program	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0			17.00
18.00	Homemaker Service	0	0	0			18.00
19.00	All Others (specify)	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	847,308	198,519	847,308			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.		0.305984				21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141313 HHA CCN: 147202 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-2 Part II Date/Time Prepared: 2/10/2016 3:52 pm

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	Cost Center Description	CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	NEW CLINIC BUILDING (SQUARE FEET)	NEW NEW MED SURG (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	
		1.00	1.01	1.02	2.00	4.00	5A.01	
1.00	Administrative and General	0	1,594	0	6,456	471,332	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	1,594	0	6,456	471,332		20.00
21.00	Total cost to be allocated	0	5,691	0	6,498	80,938		21.00
22.00	Unit cost multiplier	0.000000	3.570263	0.000000	1.006506	0.171722		22.00

	Cost Center Description	ADMINISTRATIVE AND GENERAL (ACCUM. COST)	Reconciliation	A&G HOSPITAL ONLY (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-CLINIC (SQUARE FEET)	
		5.01	5A.02	5.02	6.00	7.00	7.01	
1.00	Administrative and General	93,127	-106,998	0	1,594	0	0	1.00
2.00	Skilled Nursing Care	540,234	-620,703	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	24,445	-28,086	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	657,806		0	1,594	0	0	20.00
21.00	Total cost to be allocated	97,981		0	15,125	0	0	21.00
22.00	Unit cost multiplier	0.148951		0.000000	9.488708	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141313 HHA CCN: 147202

Period: From 10/01/2014 To 09/30/2015

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	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	CENTRAL SERVICES & SUPPLY (COSTED REQ UISI)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	32	1,594	0	0	14,829	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	32	1,594	0	0	14,829	0	20.00
21.00	Total cost to be allocated	65	10,244	0	0	44,904	0	21.00
22.00	Unit cost multiplier	2.031250	6.426600	0.000000	0.000000	3.028121	0.000000	22.00

	Cost Center Description	PHARMACY (COSTED REQ UISI)	MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)				
		15.00	16.00	19.00				
1.00	Administrative and General	0	1,644,659	0				1.00
2.00	Skilled Nursing Care	0	0	0				2.00
3.00	Physical Therapy	0	0	0				3.00
4.00	Occupational Therapy	0	0	0				4.00
5.00	Speech Pathology	0	0	0				5.00
6.00	Medical Social Services	0	0	0				6.00
7.00	Home Health Aide	0	0	0				7.00
8.00	Supplies (see instructions)	0	0	0				8.00
9.00	Drugs	0	0	0				9.00
10.00	DME	0	0	0				10.00
11.00	Home Dialysis Aide Services	0	0	0				11.00
12.00	Respiratory Therapy	0	0	0				12.00
13.00	Private Duty Nursing	0	0	0				13.00
14.00	Clinic	0	0	0				14.00
15.00	Health Promotion Activities	0	0	0				15.00
16.00	Day Care Program	0	0	0				16.00
17.00	Home Delivered Meals Program	0	0	0				17.00
18.00	Homemaker Service	0	0	0				18.00
19.00	All Others (specify)	0	0	0				19.00
20.00	Total (sum of lines 1-19)	0	1,644,659	0				20.00
21.00	Total cost to be allocated	0	21,183	0				21.00
22.00	Unit cost multiplier	0.000000	0.012880	0.000000				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 141313 HHA CCN: 147202 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-3 Part I Date/Time Prepared: 2/10/2016 3:52 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	810,628		810,628	12,978	62.46	1.00
2.00	Physical Therapy	3.00	0	252,895	252,895	4,113	61.49	2.00
3.00	Occupational Therapy	4.00	0	61,891	61,891	1,700	36.41	3.00
4.00	Speech Pathology	5.00	0	30,461	30,461	163	186.88	4.00
5.00	Medical Social Services	6.00	0		0	4	0.00	5.00
6.00	Home Health Aide	7.00	36,680		36,680	657	55.83	6.00
7.00	Total (sum of lines 1-6)		847,308	345,247	1,192,555	19,615		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	2,909			8.00
8.01	Skilled Nursing Care		99915	0	0			8.01
9.00	Physical Therapy		99914	0	1,070			9.00
9.01	Physical Therapy		99915	0	0			9.01
10.00	Occupational Therapy		99914	0	351			10.00
10.01	Occupational Therapy		99915	0	0			10.01
11.00	Speech Pathology		99914	0	67			11.00
11.01	Speech Pathology		99915	0	0			11.01
12.00	Medical Social Services		99914	0	2			12.00
12.01	Medical Social Services		99915	0	0			12.01
13.00	Home Health Aide		99914	0	165			13.00
13.01	Home Health Aide		99915	0	0			13.01
14.00	Total (sum of lines 8-13)			0	4,564			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	5,141	5,141	8,780	0.585535	15.00
16.00	Cost of Drugs	9.00	0	248	248	295	0.840678	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2,909		0	181,696		1.00
2.00	Physical Therapy	0	1,070		0	65,794		2.00
3.00	Occupational Therapy	0	351		0	12,780		3.00
4.00	Speech Pathology	0	67		0	12,521		4.00
5.00	Medical Social Services	0	2		0	0		5.00
6.00	Home Health Aide	0	165		0	9,212		6.00
7.00	Total (sum of lines 1-6)	0	4,564		0	282,003		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 141313 HHA CCN: 147202 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-3 Part I Date/Time Prepared: 2/10/2016 3:52 pm

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		108	0		91	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	181,696	1.00
2.00	Physical Therapy	65,794	2.00
3.00	Occupational Therapy	12,780	3.00
4.00	Speech Pathology	12,521	4.00
5.00	Medical Social Services	0	5.00
6.00	Home Health Aide	9,212	6.00
7.00	Total (sum of lines 1-6)	282,003	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.618809	408,681	252,895	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.431826	143,325	61,891	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	1.992450	15,288	30,461	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.585516	8,780	5,141	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.842229	295	248	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141313 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-4 Part I-II

HHA CCN: 147202 | Date/Time Prepared: 2/10/2016 3:52 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	91	0	1.00
2.00	Total charges	0	108	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	108	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	17	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	91	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	593,565	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	11,552	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	6,621	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	7,470	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	3,447	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	1,433	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	624,179	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	624,179	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	624,179	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	624,179	29.00
30.00	OTHER ADJUSTMENTS (FROM PS&R)	0	-1,371	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	622,808	31.00
31.01	Sequestration adjustment (see instructions)	0	12,455	31.01
32.00	Interim payments (see instructions)	0	610,324	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	29	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 141313 HHA CCN: 147202 | Period: From 10/01/2014 To 09/30/2015 | Worksheet H-5 | Date/Time Prepared: 2/10/2016 3:52 pm

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		610,324	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		610,324	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		29	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		610,353	7.00

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

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

Provider CCN: 141313 | Component CCN: 143457 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/10/2016 3:52 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,365,211	0	1,365,211	-165,457	1,199,754	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	310,541	0	310,541	0	310,541	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	382,323	0	382,323	0	382,323	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,058,075	0	2,058,075	-165,457	1,892,618	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	16,100	16,100	0	16,100	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	16,100	16,100	0	16,100	14.00
15.00	Medical Supplies	0	48,827	48,827	0	48,827	15.00
16.00	Transportation (Health Care Staff)	0	1,176	1,176	0	1,176	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	60,283	60,283	0	60,283	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	110,286	110,286	0	110,286	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,058,075	126,386	2,184,461	-165,457	2,019,004	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	1,854	1,854	0	1,854	29.00
30.00	Administrative Costs	382,116	347,055	729,171	0	729,171	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	382,116	348,909	731,025	0	731,025	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,440,191	475,295	2,915,486	-165,457	2,750,029	32.00

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

Provider CCN: 141313 | Component CCN: 143457 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/10/2016 3:52 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,199,754		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	310,541		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	382,323		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,892,618		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	16,100		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	16,100		14.00
15.00	Medical Supplies	0	48,827		15.00
16.00	Transportation (Health Care Staff)	0	1,176		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	60,283		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	110,286		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,019,004		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	1,854		29.00
30.00	Administrative Costs	-435	728,736		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-435	730,590		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-435	2,749,594		32.00

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

Provider CCN: 141313 Component CCN: 143462 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/10/2016 3:52 pm

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	30,968	0	30,968	0	30,968	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	143,747	0	143,747	0	143,747	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	56,810	0	56,810	0	56,810	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	231,525	0	231,525	0	231,525	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	1,901	1,901	0	1,901	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1,901	1,901	0	1,901	14.00
15.00	Medical Supplies	0	1,369	1,369	0	1,369	15.00
16.00	Transportation (Health Care Staff)	0	4,112	4,112	0	4,112	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	5,481	5,481	0	5,481	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	231,525	7,382	238,907	0	238,907	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	6,081	6,081	0	6,081	29.00
30.00	Administrative Costs	51,695	42,589	94,284	0	94,284	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	51,695	48,670	100,365	0	100,365	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	283,220	56,052	339,272	0	339,272	32.00

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

Provider CCN: 141313 | Component CCN: 143462 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/10/2016 3:52 pm

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	30,968		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	143,747		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	56,810		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	231,525		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	1,901		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	1,901		14.00
15.00	Medical Supplies	0	1,369		15.00
16.00	Transportation (Health Care Staff)	0	4,112		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	5,481		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	238,907		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	6,081		29.00
30.00	Administrative Costs	-287	93,997		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-287	100,078		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-287	338,985		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141313 | Component CCN: 143457 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-2 | Date/Time Prepared: 2/10/2016 3:52 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.56	8,089	4,200	6,552		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.57	4,174	2,100	3,297		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.13	12,263		9,849	12,263	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	0.66	554			554	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)	3.79	12,817			12,817	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					2,019,004	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)					2,019,004	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)					730,590	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					1,296,833	15.00
16.00	Total overhead (sum of lines 14 and 15)					2,027,423	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					2,027,423	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					2,027,423	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					4,046,427	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141313 | Component CCN: 143462 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-2 | Date/Time Prepared: 2/10/2016 3:52 pm

Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.11	459	4,200	462		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.54	1,362	2,100	1,134		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.65	1,821		1,596	1,821	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.65	1,821			1,821	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)					238,907	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)					238,907	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)					100,078	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					110,837	15.00
16.00	Total overhead (sum of lines 14 and 15)					210,915	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					210,915	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					210,915	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					449,822	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2014 To 09/30/2015	Worksheet M-3 Date/Time Prepared: 2/10/2016 3:52 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		4,046,427	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		45,972	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		4,000,455	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		12,817	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)		12,817	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		312.12	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)	312.12	312.12	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	4,093	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,277,507	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		1,277,507	16.00
16.01	Total program charges (see instructions)(from contractor's records)		683,236	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		8,617	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		16,112	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.)		953,174	16.04
16.05	Total program cost (see instructions)		969,286	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		69,928	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		120,938	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		969,286	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		24,444	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		993,730	22.00
23.00	Allowable bad debts (see instructions)		42,883	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		27,874	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		42,883	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		1,021,604	26.00
26.01	Sequestration adjustment (see instructions)		20,432	26.01
27.00	Interim payments		902,346	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)		98,826	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2014 To 09/30/2015	Worksheet M-3 Date/Time Prepared: 2/10/2016 3:52 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		449,822	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		3,543	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		446,279	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,821	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		1,821	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		245.07	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)	245.07	245.07	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	250	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	61,268	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) *		61,268	16.00
16.01	Total program charges (see instructions)(from contractor's records)		40,871	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,100	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,649	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.)		43,944	16.04
16.05	Total program cost (see instructions)		45,593	16.05
17.00	Primary payer amounts		51	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,689	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		7,016	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		45,542	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		2,126	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		47,668	22.00
23.00	Allowable bad debts (see instructions)		1,614	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		1,049	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,614	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		48,717	26.00
26.01	Sequestration adjustment (see instructions)		974	26.01
27.00	Interim payments		29,571	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)		18,172	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: 141313 Component CCN: 143457	Period: From 10/01/2014 To 09/30/2015	Worksheet M-4 Date/Time Prepared: 2/10/2016 3:52 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,892,618	1,892,618	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000400	0.003138	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	757	5,939	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	6,009	10,233	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	6,766	16,172	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	2,019,004	2,019,004	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	2,027,423	2,027,423	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003351	0.008010	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	6,794	16,240	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	13,560	32,412	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	73	572	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	185.75	56.66	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	41	297	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	7,616	16,828	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)		45,972	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)		24,444	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 141313 Component CCN: 143462	Period: From 10/01/2014 To 09/30/2015	Worksheet M-4 Date/Time Prepared: 2/10/2016 3:52 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	231,525	231,525	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000415	0.001454	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	96	337	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	823	626	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	919	963	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	238,907	238,907	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	210,915	210,915	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003847	0.004031	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	811	850	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,730	1,813	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	10	35	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	173.00	51.80	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	21	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,038	1,088	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		3,543	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		2,126	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141313 Component CCN: 143457	Period: From 10/01/2014 To 09/30/2015	Worksheet M-5 Date/Time Prepared: 2/10/2016 3:52 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		761,246	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		04/21/2015	141,100	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)		141,100	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		902,346	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		98,826	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,001,172	7.00

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

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

Provider CCN: 141313 | Component CCN: 143462 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-5 | Date/Time Prepared: 2/10/2016 3:52 pm

Rural Health Clinic (RHC) II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		29,571	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		29,571	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		18,172	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		47,743	7.00

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