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: 141318	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/27/2016 2:40 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/27/2016 Time: 2:40 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by OSF HOLY FAMILY MED CTR (141318) 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	-80,155	-134,228	1	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	-65,942	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-86,927		0	10.00
200.00	Total	0	-146,097	-221,155	1	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: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2016 2:39 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 WEST HARLEM AVENUE	PO Box:			1.00
2.00	City: MONMOUTH	State: IL	Zip Code: 61462	County: WARREN	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	OSF HOLY FAMILY MED CTR	141318	14000	1	05/01/2002	N	O	P	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	OSF HOLY FAMILY SWING BEDS	14Z318	14000		05/01/2002	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	OSF HOLY FAMILY CLINICS	143461	14000		02/05/2003	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2014	09/30/2015	20.00
21.00	Type of Control (see instructions)	1		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	0	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: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2016 2:39 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.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
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: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2016 2:39 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: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2016 2:39 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)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	90,000	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141318	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/27/2016 2:39 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)	Y	149006	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: OSF HEALTHCARE SYSTEM	Contractor's Name: NGS	Contractor's Number: 06101	141.00
142.00	Street: 800 N.E. GLEN OAK AVENUE	PO Box:		142.00
143.00	City: PEORIA	State: IL	Zip Code: 61603	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)	1	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)	10/12/2014	09/30/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141318	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/27/2016 2:39 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)		Y	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/27/2016 2:39 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	12/15/2014	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: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/27/2016 2:39 pm

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CAROLE	WAHL	41.00
42.00	Enter the employer/company name of the cost report preparer.	OSF HEALTHCARE SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(309)655-2855	CAROLE.M.WAHL@OSFHEALTHCARE.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 2/27/2016 2:39 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)	12/15/2014			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.		GOVERNMENT REPORTING SENIOR ANALYST		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: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2016 2:39 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	23	8,395	22,944.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		23	8,395	22,944.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		23	8,395	22,944.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		23				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: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2016 2:39 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)	559	108	956			1.00
2.00	HMO and other (see instructions)	102	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	589	0	842			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,148	108	1,798			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,148	108	1,798	0.00	105.51	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	6,890	0	38,681	0.00	11.33	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	116.84	27.00
28.00	Observation Bed Days		24	206			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2016 2:39 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	185	17	308	1.00
2.00	HMO and other (see instructions)			33	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	185	17	308	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141318 | Component CCN: 143461 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-8 | Date/Time Prepared: 2/27/2016 2:39 pm

					Rural Health Clinic (RHC) I	Cost	
					1.00		
	Clinic Address and Identification						
1.00	Street				1000 W. HARLEM		1.00
			City		State	ZIP Code	
			1.00		2.00	3.00	
2.00	City, State, ZIP Code, County		MONMOUTH		ILLINOIS	61462	2.00
						1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
					Grant Award	Date	
					1.00	2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)				0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00
7.00	Appalachian Regional Commission				0		7.00
8.00	Look-Alikes				0		8.00
9.00	OTHER (SPECIFY)				0		9.00
					1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:00	20:00	07:00	11.00

					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	Provider name, CCN number						14.00

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		WARREN				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	20:00	07:00	20:00	07:00	20:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141318 Component CCN: 143461	Period: From 10/01/2014 To 09/30/2015	Worksheet S-8 Date/Time Prepared: 2/27/2016 2:39 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	07:00	20:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-10 | Date/Time Prepared: 2/27/2016 2:39 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)	0.378274	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	5,181,475	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?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	13,119,792	6.00
7.00	Medicaid cost (line 1 times line 6)	4,962,876	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)	0	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	0	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	897,208	1,538,248	2,435,456	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	339,390	581,879	921,269	21.00
22.00	Partial payment by patients approved for charity care	23,840	19,648	43,488	22.00
23.00	Cost of charity care (line 21 minus line 22)	315,550	562,231	877,781	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)	1,130,803	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	81,566	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,049,237	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	396,899	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,274,680	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,274,680	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/27/2016 2:39 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		109,738	109,738	441,222	550,960	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		363,206	363,206	389,937	753,143	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,478	2,534,680	2,540,158	1,023,555	3,563,713	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,542,896	4,261,746	5,804,642	-73,606	5,731,036	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	334,012	928,947	1,262,959	-313,974	948,985	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	140,153	140,153	8.00
9.00	00900	HOUSEKEEPING	305,212	164,337	469,549	-148,921	320,628	9.00
10.00	01000	DIETARY	290,649	199,918	490,567	-20,743	469,824	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	197,223	15,075	212,298	-2,273	210,025	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	944,731	118,553	1,063,284	-79,385	983,899	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	437,829	298,492	736,321	-234,834	501,487	50.00
53.00	05300	ANESTHESIOLOGY	206,558	82,659	289,217	-25,023	264,194	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	489,235	309,215	798,450	-75,257	723,193	54.00
56.00	05600	RADIOISOTOPE	55,442	115,795	171,237	-23,041	148,196	56.00
57.00	05700	CT SCAN	0	329,583	329,583	-21,679	307,904	57.00
58.00	05800	MRI	0	237,033	237,033	-6,807	230,226	58.00
60.00	06000	LABORATORY	451,747	576,525	1,028,272	-27,990	1,000,282	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	14,426	14,426	10,584	25,010	65.00
66.00	06600	PHYSICAL THERAPY	276,694	14,066	290,760	-12,359	278,401	66.00
67.00	06700	OCCUPATIONAL THERAPY	84,874	3,079	87,953	-2,914	85,039	67.00
68.00	06800	SPEECH PATHOLOGY	19,122	-1,647	17,475	-3	17,472	68.00
69.00	06900	ELECTROCARDIOLOGY	180,358	18,505	198,863	-16,660	182,203	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,200	21,996	27,196	231,036	258,232	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	90,795	90,795	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	275,448	1,043,846	1,319,294	177,345	1,496,639	73.00
76.00	03950	DIABETIC SERVICES	88,625	14,125	102,750	-2,101	100,649	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,272,835	2,534,651	5,807,486	-1,188,651	4,618,835	88.00
91.00	09100	EMERGENCY	882,179	1,407,135	2,289,314	-76,987	2,212,327	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,346,347	15,715,684	26,062,031	151,419	26,213,450	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	947,404	306,259	1,253,663	-151,419	1,102,244	192.00
200.00		TOTAL (SUM OF LINES 118-199)	11,293,751	16,021,943	27,315,694	0	27,315,694	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/27/2016 2:39 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	81,100	632,060		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	55,511	808,654		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-39,051	3,524,662		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-445,029	5,286,007		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0		6.00
7.00	00700	OPERATION OF PLANT	0	948,985		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	140,153		8.00
9.00	00900	HOUSEKEEPING	0	320,628		9.00
10.00	01000	DIETARY	-25,056	444,768		10.00
11.00	01100	CAFETERIA	0	0		11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0		14.00
15.00	01500	PHARMACY	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-8,519	201,506		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	983,899		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	501,487		50.00
53.00	05300	ANESTHESIOLOGY	-206,558	57,636		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	723,193		54.00
56.00	05600	RADIOISOTOPE	0	148,196		56.00
57.00	05700	CT SCAN	0	307,904		57.00
58.00	05800	MRI	-43,440	186,786		58.00
60.00	06000	LABORATORY	-13,200	987,082		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	25,010		65.00
66.00	06600	PHYSICAL THERAPY	0	278,401		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	85,039		67.00
68.00	06800	SPEECH PATHOLOGY	0	17,472		68.00
69.00	06900	ELECTROCARDIOLOGY	0	182,203		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	258,232		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	90,795		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-724,503	772,136		73.00
76.00	03950	DIABETIC SERVICES	0	100,649		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-5,228	4,613,607		88.00
91.00	09100	EMERGENCY	-1,001,589	1,210,738		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,375,562	23,837,888		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,102,244		192.00
200.00		TOTAL (SUM OF LINES 118-199)	-2,375,562	24,940,132		200.00

RECLASSIFICATIONS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/27/2016 2:39 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	B - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	237,838		1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	190,583		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
	TOTALS		0	428,421		
	C - RT SALARIES					
1.00	RESPIRATORY THERAPY	65.00	24,090	0		1.00
2.00		0.00	0	0		2.00
	0		24,090	0		
	D - A&G EXPENSES					
1.00	MEDICAL RECORDS & LIBRARY	16.00	1,976	0		1.00
	0		1,976	0		
	E - RHC PHYSICIAN RECRUITMENT					
1.00		0.00	0	0		1.00
	0		0	0		
	F - PROPERTY INSURANCE					
1.00	OTHER CAP REL COSTS	3.00	0	20,815		1.00
	0		0	20,815		
	G - EMPLOYEE BENEFIT RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,023,555		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
	0		0	1,023,555		
	I - DEPRECIATION RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	428,977		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	381,367		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00

RECLASSIFICATIONS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/27/2016 2:39 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	0		0	810,344		
	J - LAUNDRY RECLASS					
1.00	LAUNDRY & LINEN SERVICE	8.00	28,305	111,848		1.00
	0		28,305	111,848		
	K - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	90,795		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	0		0	90,795		
	L - CLINIC A&G					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	62,122		1.00
2.00		0.00	0	0		2.00
	0		0	62,122		
500.00	Grand Total: Increases		54,371	2,547,900		500.00

RECLASSIFICATIONS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/27/2016 2:39 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	16,017	0		1.00
2.00	OPERATING ROOM	50.00	0	82,332	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	10,361	0		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,046	0		4.00
5.00	RADIOISOTOPE	56.00	0	21,432	0		5.00
6.00	CT SCAN	57.00	0	18,283	0		6.00
7.00	MRI	58.00	0	3,735	0		7.00
8.00	LABORATORY	60.00	0	5,335	0		8.00
9.00	RESPIRATORY THERAPY	65.00	0	13,506	0		9.00
10.00	PHYSICAL THERAPY	66.00	0	3,329	0		10.00
11.00	OCCUPATIONAL THERAPY	67.00	0	570	0		11.00
12.00	ELECTROCARDIOLOGY	69.00	0	890	0		12.00
13.00	DIABETIC SERVICES	76.00	0	153	0		13.00
14.00	RURAL HEALTH CLINIC	88.00	0	171,681	0		14.00
15.00	EMERGENCY	91.00	0	45,075	0		15.00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	24,676	0		16.00
	TOTALS		0	428,421			
	C - RT SALARIES						
1.00	ADULTS & PEDIATRICS	30.00	17,103	0	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	6,987	0	0		2.00
	0		24,090	0			
	D - A&G EXPENSES						
1.00	RURAL HEALTH CLINIC	88.00	1,976	0	0		1.00
	0		1,976	0			
	E - RHC PHYSICIAN RECRUITMENT						
1.00		0.00	0	0	0		1.00
	0		0	0			
	F - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	20,815	0		1.00
	0		0	20,815			
	G - EMPLOYEE BENEFIT RECLASS						
1.00		0.00	0	0	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	27,948	0		2.00
3.00	OPERATION OF PLANT	7.00	0	1,870	0		3.00
4.00	HOUSEKEEPING	9.00	0	7,843	0		4.00
5.00	DIETARY	10.00	0	7,726	0		5.00
6.00	MEDICAL RECORDS & LIBRARY	16.00	0	3,774	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	24,894	0		7.00
8.00	OPERATING ROOM	50.00	0	12,736	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,025	0		9.00
10.00	RADIOISOTOPE	56.00	0	1,609	0		10.00
11.00	LABORATORY	60.00	0	11,950	0		11.00
12.00	PHYSICAL THERAPY	66.00	0	6,660	0		12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	2,343	0		13.00
14.00	SPEECH PATHOLOGY	68.00	0	3	0		14.00
15.00	ELECTROCARDIOLOGY	69.00	0	4,151	0		15.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	7,508	0		16.00
17.00	DIABETIC SERVICES	76.00	0	1,948	0		17.00
18.00	RURAL HEALTH CLINIC	88.00	0	761,291	0		18.00
19.00	EMERGENCY	91.00	0	18,043	0		19.00
20.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	110,233	0		20.00
	0		0	1,023,555			
	I - DEPRECIATION RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	86,965	9		1.00
2.00	OPERATION OF PLANT	7.00	0	312,104	9		2.00
3.00	HOUSEKEEPING	9.00	0	925	0		3.00
4.00	DIETARY	10.00	0	13,017	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	475	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	21,367	0		6.00
7.00	OPERATING ROOM	50.00	0	49,277	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	14,662	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	53,186	0		9.00
10.00	CT SCAN	57.00	0	3,396	0		10.00
11.00	MRI	58.00	0	3,072	0		11.00
12.00	LABORATORY	60.00	0	10,705	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	2,370	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	4,632	0		14.00
15.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,802	0		15.00
16.00	DRUGS CHARGED TO PATIENTS	73.00	0	5,730	0		16.00
17.00	RURAL HEALTH CLINIC	88.00	0	200,597	0		17.00
18.00	EMERGENCY	91.00	0	13,819	0		18.00
19.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7,243	0		19.00

RECLASSIFICATIONS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/27/2016 2:39 pm

		Decreases				
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	0		0	810,344		
	J - LAUNDRY RECLASS					
1.00	HOUSEKEEPING	9.00	28,305	111,848	0	1.00
	0		28,305	111,848		
	K - IMPLANTABLE DEVICES					
1.00	ADULTS & PEDIATRICS	30.00	0	4	0	1.00
2.00	EMERGENCY	91.00	0	50	0	2.00
3.00	RURAL HEALTH CLINIC	88.00	0	91	0	3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	157	0	4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3	0	5.00
6.00	OPERATING ROOM	50.00	0	90,489	0	6.00
7.00	OCCUPATIONAL THERAPY	67.00	0	1	0	7.00
	0		0	90,795		
	L - CLINIC A&G					
1.00	RURAL HEALTH CLINIC	88.00	0	53,015	0	1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	9,107	0	2.00
	0		0	62,122		
500.00	Grand Total: Decreases		54,371	2,547,900		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I Date/Time Prepared: 2/27/2016 2:39 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	325,000	0	0	0	0	1.00
2.00	Land Improvements	188,447	0	0	0	0	2.00
3.00	Buildings and Fixtures	10,045,252	65,601	0	65,601	322,489	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	6,756,615	468,627	0	468,627	14,975	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,315,314	534,228	0	534,228	337,464	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	17,315,314	534,228	0	534,228	337,464	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	325,000	0	1.00
2.00	Land Improvements	188,447	0	2.00
3.00	Buildings and Fixtures	9,788,364	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	7,210,267	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,512,078	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	17,512,078	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 2/27/2016 2:39 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	109,738	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	363,206	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	472,944	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	109,738		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	363,206		2.00
3.00	Total (sum of lines 1-2)	0	472,944		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 2/27/2016 2:39 pm

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	10,301,811	0	10,301,811	0.588269	12,245	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7,210,266	0	7,210,266	0.411731	8,570	2.00
3.00	Total (sum of lines 1-2)	17,512,077	0	17,512,077	1.000000	20,815	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	12,245	619,815	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	8,570	800,084	0	2.00
3.00	Total (sum of lines 1-2)	0	0	20,815	1,419,899	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	0	12,245	0	0	632,060	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,570	0	0	808,654	2.00
3.00	Total (sum of lines 1-2)	0	20,815	0	0	1,440,714	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/27/2016 2:39 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-38,592	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-2,364	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-5,856	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,221,347			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	325,949			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-25,056	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-8,519	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients	B	-724,503	DRUGS CHARGED TO PATIENTS	73.00	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)	B	-10,507	ADMINISTRATIVE & GENERAL	5.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	RHC OTHER INCOME	B	-5,228	RURAL HEALTH CLINIC	88.00	0	33.00
33.01			0		0.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/27/2016 2:39 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02			0		0.00	0	33.02
34.00	MARKETING AND DEVELOPMENT SALAR	A	-8,554	ADMINISTRATIVE & GENERAL	5.00	0	34.00
34.01	MARKETING & DEVELOPMENT BENEFIT	A	-770	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	34.01
34.02	MARKETING & DEVELOPMENT OTHER	A	-31,183	ADMINISTRATIVE & GENERAL	5.00	0	34.02
34.03			0		0.00	0	34.03
34.04			0		0.00	0	34.04
34.05	ADVERTISING EXPENSE	A	-112,109	ADMINISTRATIVE & GENERAL	5.00	0	34.05
35.00	LOBBYING	A	-13,755	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00			0		0.00	0	36.00
36.01			0		0.00	0	36.01
36.02			0		0.00	0	36.02
37.00	ER BENEFITS	A	-38,281	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	37.00
38.00			0		0.00	0	38.00
38.01	ALCOHOLIC BEVERAGES	A	-772	ADMINISTRATIVE & GENERAL	5.00	0	38.01
38.02	PROVIDER TAX IDPA	A	-452,679	ADMINISTRATIVE & GENERAL	5.00	0	38.02
38.03	CAR ALLOWANCE	A	-1,436	ADMINISTRATIVE & GENERAL	5.00	0	38.03
40.00			0		0.00	0	40.00
41.00			0		0.00	0	41.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,375,562				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141318	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-1 Date/Time Prepared: 2/27/2016 2:39 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	CORP OFFICE CHARGES	2,586,354	2,977,702	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	INTEREST EXP CORP OFFICE	624,126	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	PHYSICIAN RECRUITING	11,935	11,935	3.00
3.01	58.00	MRI	MOBILE MRI	245,225	245,225	3.01
3.02	58.00	MRI	ET MAINTENANCE AGREEMENT	66,572	110,012	3.02
4.00	1.00	CAP REL COSTS-BLDG & FIXT	CORP OFFICE CHARGES	81,100	0	4.00
4.01	2.00	CAP REL COSTS-MVBLE EQUIP	CORP OFFICE CHARGES	370,476	314,965	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,985,788	3,659,839	5.00

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

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

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

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

6.00	B	OSF HEALTHCARE SYSTEM	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141318	Period: From 10/01/2014 To 09/30/2015	Worksheet A-8-1 Date/Time Prepared: 2/27/2016 2:39 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-391,348	0		1.00
2.00	624,126	0		2.00
3.00	0	0		3.00
3.01	0	0		3.01
3.02	-43,440	0		3.02
4.00	81,100	9		4.00
4.01	55,511	9		4.01
5.00	325,949			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/27/2016 2:39 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	1,449,735	1,001,589	448,146	0	0	1.00
2.00	60.00	LABORATORY	13,200	13,200	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	206,558	206,558	0	0	0	3.00
4.00	0.00		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			1,669,493	1,221,347	448,146		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	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	0.00		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	1,001,589		1.00
2.00	60.00	LABORATORY	0	0	0	13,200		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	206,558		3.00
4.00	0.00		0	0	0	0		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	1,221,347		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/27/2016 2:39 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	632,060	632,060				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	808,654		808,654			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,524,662	0	0	3,524,662		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,286,007	73,405	103,252	498,223	5,960,887	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	948,985	97,732	137,472	107,857	1,292,046	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	140,153	0	0	9,140	149,293	8.00
9.00	00900	HOUSEKEEPING	320,628	7,658	10,772	89,417	428,475	9.00
10.00	01000	DIETARY	444,768	43,371	61,006	93,855	643,000	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	201,506	17,242	0	64,324	283,072	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	983,899	69,691	98,028	299,544	1,451,162	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	501,487	35,253	49,587	141,381	727,708	50.00
53.00	05300	ANESTHESIOLOGY	57,636	1,518	2,136	0	61,290	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	723,193	32,985	46,397	157,981	960,556	54.00
56.00	05600	RADIOISOTOPE	148,196	0	0	17,903	166,099	56.00
57.00	05700	CT SCAN	307,904	0	0	0	307,904	57.00
58.00	05800	MRI	186,786	0	0	0	186,786	58.00
60.00	06000	LABORATORY	987,082	12,489	17,568	145,875	1,163,014	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	25,010	0	0	7,779	32,789	65.00
66.00	06600	PHYSICAL THERAPY	278,401	21,350	30,032	89,348	419,131	66.00
67.00	06700	OCCUPATIONAL THERAPY	85,039	1,847	0	27,407	114,293	67.00
68.00	06800	SPEECH PATHOLOGY	17,472	230	0	6,175	23,877	68.00
69.00	06900	ELECTROCARDIOLOGY	182,203	8,440	11,872	55,984	258,499	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	258,232	23,191	32,621	1,679	315,723	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	90,795	0	0	0	90,795	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	772,136	7,303	10,273	88,946	878,658	73.00
76.00	03950	DIABETIC SERVICES	100,649	8,079	0	28,618	137,346	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,613,607	102,971	144,842	1,056,208	5,917,628	88.00
91.00	09100	EMERGENCY	1,210,738	37,534	52,796	231,088	1,532,156	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,837,888	602,289	808,654	3,218,732	23,502,187	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	1,102,244	29,771	0	305,930	1,437,945	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	24,940,132	632,060	808,654	3,524,662	24,940,132	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/27/2016 2:39 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,960,887					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	405,798	0	1,697,844			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	46,889	0	0	196,182		8.00
9.00	00900	HOUSEKEEPING	134,573	0	28,209	1,399	592,656	9.00
10.00	01000	DIETARY	201,950	0	159,760	0	56,709	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	88,906	0	63,512	0	22,544	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	455,772	0	256,711	79,941	91,122	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	228,554	0	129,856	20,200	46,094	50.00
53.00	05300	ANESTHESIOLOGY	19,250	0	5,593	0	1,985	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	301,686	0	121,503	29,706	43,129	54.00
56.00	05600	RADIOISOTOPE	52,167	0	0	0	0	56.00
57.00	05700	CT SCAN	96,705	0	0	0	0	57.00
58.00	05800	MRI	58,665	0	0	0	0	58.00
60.00	06000	LABORATORY	365,272	0	46,005	168	16,330	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	10,298	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	131,638	0	78,645	16,947	27,916	66.00
67.00	06700	OCCUPATIONAL THERAPY	35,896	0	6,804	0	2,415	67.00
68.00	06800	SPEECH PATHOLOGY	7,499	0	847	0	301	68.00
69.00	06900	ELECTROCARDIOLOGY	81,188	0	31,090	803	11,036	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	99,160	0	85,425	0	30,323	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,516	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	275,964	0	26,901	0	9,549	73.00
76.00	03950	DIABETIC SERVICES	43,137	0	29,758	0	10,563	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,858,573	0	379,303	0	134,638	88.00
91.00	09100	EMERGENCY	481,210	0	138,259	41,081	49,076	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,509,266	0	1,588,181	190,245	553,730	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	451,621	0	109,663	5,937	38,926	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,960,887	0	1,697,844	196,182	592,656	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/27/2016 2:39 pm

		Cost Center Description	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,061,419					10.00
11.00	01100	CAFETERIA	930,552	930,552				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63,174	0	0	521,208	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	130,867	221,739	0	0	21,168	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	90,970	0	0	26,448	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	7,723	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	112,829	0	0	40,614	54.00
56.00	05600	RADIOISOTOPE	0	5,054	0	0	8,463	56.00
57.00	05700	CT SCAN	0	0	0	0	51,298	57.00
58.00	05800	MRI	0	0	0	0	20,778	58.00
60.00	06000	LABORATORY	0	152,123	0	0	102,804	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	6,949	0	0	4,620	65.00
66.00	06600	PHYSICAL THERAPY	0	50,539	0	0	18,000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,635	0	0	4,641	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,606	68.00
69.00	06900	ELECTROCARDIOLOGY	0	35,883	0	0	22,073	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	11,895	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	2,665	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,213	0	0	36,417	73.00
76.00	03950	DIABETIC SERVICES	0	10,108	0	0	283	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	62,416	0	0	65,124	88.00
91.00	09100	EMERGENCY	0	97,920	0	0	74,588	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,061,419	930,552	0	0	521,208	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,061,419	930,552	0	0	521,208	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/27/2016 2:39 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,708,482	0	2,708,482		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,269,830	0	1,269,830		50.00
53.00	05300	ANESTHESIOLOGY	95,841	0	95,841		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,610,023	0	1,610,023		54.00
56.00	05600	RADIOISOTOPE	231,783	0	231,783		56.00
57.00	05700	CT SCAN	455,907	0	455,907		57.00
58.00	05800	MRI	266,229	0	266,229		58.00
60.00	06000	LABORATORY	1,845,716	0	1,845,716		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	54,656	0	54,656		65.00
66.00	06600	PHYSICAL THERAPY	742,816	0	742,816		66.00
67.00	06700	OCCUPATIONAL THERAPY	176,684	0	176,684		67.00
68.00	06800	SPEECH PATHOLOGY	34,130	0	34,130		68.00
69.00	06900	ELECTROCARDIOLOGY	440,572	0	440,572		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	542,526	0	542,526		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	121,976	0	121,976		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,235,702	0	1,235,702		73.00
76.00	03950	DIABETIC SERVICES	231,195	0	231,195		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	8,417,682	0	8,417,682		88.00
91.00	09100	EMERGENCY	2,414,290	0	2,414,290		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,896,040	0	22,896,040		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,044,092	0	2,044,092		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	24,940,132	0	24,940,132		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/27/2016 2:39 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	452,903	73,405	103,252	629,560	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	97,732	137,472	235,204	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	7,658	10,772	18,430	0	9.00
10.00	01000	DIETARY	0	43,371	61,006	104,377	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	17,242	0	17,242	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	69,691	98,028	167,719	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	35,253	49,587	84,840	0	50.00
53.00	05300	ANESTHESIOLOGY	0	1,518	2,136	3,654	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	86,032	32,985	46,397	165,414	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	193,961	0	0	193,961	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	30,607	12,489	17,568	60,664	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	21,350	30,032	51,382	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,847	0	1,847	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	230	0	230	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	8,440	11,872	20,312	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	23,191	32,621	55,812	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,303	10,273	17,576	0	73.00
76.00	03950	DIABETIC SERVICES	0	8,079	0	8,079	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	102,971	144,842	247,813	0	88.00
91.00	09100	EMERGENCY	0	37,534	52,796	90,330	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	763,503	602,289	808,654	2,174,446	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	29,771	0	29,771	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	763,503	632,060	808,654	2,204,217	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/27/2016 2:39 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	629,560					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	42,858	0	278,062			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,952	0	0	4,952		8.00
9.00	00900	HOUSEKEEPING	14,213	0	4,620	35	37,298	9.00
10.00	01000	DIETARY	21,329	0	26,164	0	3,569	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	9,390	0	10,402	0	1,419	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	48,136	0	42,042	2,018	5,735	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	24,139	0	21,267	510	2,901	50.00
53.00	05300	ANESTHESIOLOGY	2,033	0	916	0	125	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	31,863	0	19,899	750	2,714	54.00
56.00	05600	RADIOISOTOPE	5,510	0	0	0	0	56.00
57.00	05700	CT SCAN	10,213	0	0	0	0	57.00
58.00	05800	MRI	6,196	0	0	0	0	58.00
60.00	06000	LABORATORY	38,578	0	7,534	4	1,028	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,088	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	13,903	0	12,880	428	1,757	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,791	0	1,114	0	152	67.00
68.00	06800	SPEECH PATHOLOGY	792	0	139	0	19	68.00
69.00	06900	ELECTROCARDIOLOGY	8,575	0	5,092	20	695	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,473	0	13,990	0	1,908	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,012	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	29,146	0	4,406	0	601	73.00
76.00	03950	DIABETIC SERVICES	4,556	0	4,874	0	665	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	196,293	0	62,120	0	8,471	88.00
91.00	09100	EMERGENCY	50,823	0	22,643	1,037	3,089	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	581,862	0	260,102	4,802	34,848	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	47,698	0	17,960	150	2,450	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	629,560	0	278,062	4,952	37,298	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/27/2016 2:39 pm

		Cost Center Description	DIETARY	CAFETERIA	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	155,439					10.00
11.00	01100	CAFETERIA	136,274	136,274				11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,251	0	0	47,704	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,165	32,473	0	0	1,937	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,322	0	0	2,420	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	707	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,523	0	0	3,717	54.00
56.00	05600	RADIOISOTOPE	0	740	0	0	774	56.00
57.00	05700	CT SCAN	0	0	0	0	4,694	57.00
58.00	05800	MRI	0	0	0	0	1,901	58.00
60.00	06000	LABORATORY	0	22,278	0	0	9,415	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,018	0	0	423	65.00
66.00	06600	PHYSICAL THERAPY	0	7,401	0	0	1,647	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,850	0	0	425	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	147	68.00
69.00	06900	ELECTROCARDIOLOGY	0	5,255	0	0	2,020	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,088	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	244	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,203	0	0	3,333	73.00
76.00	03950	DIABETIC SERVICES	0	1,480	0	0	26	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	9,140	0	0	5,960	88.00
91.00	09100	EMERGENCY	0	14,340	0	0	6,826	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	155,439	136,274	0	0	47,704	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	155,439	136,274	0	0	47,704	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/27/2016 2:39 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
15.00	01500	PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	319,225	0	319,225		30.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	149,399	0	149,399		50.00
53.00	05300	ANESTHESIOLOGY	7,435	0	7,435		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	240,880	0	240,880		54.00
56.00	05600	RADIOISOTOPE	7,024	0	7,024		56.00
57.00	05700	CT SCAN	208,868	0	208,868		57.00
58.00	05800	MRI	8,097	0	8,097		58.00
60.00	06000	LABORATORY	139,501	0	139,501		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	2,529	0	2,529		65.00
66.00	06600	PHYSICAL THERAPY	89,398	0	89,398		66.00
67.00	06700	OCCUPATIONAL THERAPY	9,179	0	9,179		67.00
68.00	06800	SPEECH PATHOLOGY	1,327	0	1,327		68.00
69.00	06900	ELECTROCARDIOLOGY	41,969	0	41,969		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	83,271	0	83,271		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,256	0	3,256		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,265	0	56,265		73.00
76.00	03950	DIABETIC SERVICES	19,680	0	19,680		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	529,797	0	529,797		88.00
91.00	09100	EMERGENCY	189,088	0	189,088		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,106,188	0	2,106,188		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	98,029	0	98,029		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	2,204,217	0	2,204,217		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/27/2016 2:39 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	96,155					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		87,458				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	10,915,169			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,167	11,167	1,542,896	-5,960,887	18,979,245	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	14,868	14,868	334,012	0	1,292,046	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	28,305	0	149,293	8.00
9.00	00900	HOUSEKEEPING	1,165	1,165	276,907	0	428,475	9.00
10.00	01000	DIETARY	6,598	6,598	290,649	0	643,000	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,623	0	199,199	0	283,072	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,602	10,602	927,628	0	1,451,162	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,363	5,363	437,829	0	727,708	50.00
53.00	05300	ANESTHESIOLOGY	231	231	0	0	61,290	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,018	5,018	489,235	0	960,556	54.00
56.00	05600	RADIOISOTOPE	0	0	55,442	0	166,099	56.00
57.00	05700	CT SCAN	0	0	0	0	307,904	57.00
58.00	05800	MRI	0	0	0	0	186,786	58.00
60.00	06000	LABORATORY	1,900	1,900	451,747	0	1,163,014	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	24,090	0	32,789	65.00
66.00	06600	PHYSICAL THERAPY	3,248	3,248	276,694	0	419,131	66.00
67.00	06700	OCCUPATIONAL THERAPY	281	0	84,874	0	114,293	67.00
68.00	06800	SPEECH PATHOLOGY	35	0	19,122	0	23,877	68.00
69.00	06900	ELECTROCARDIOLOGY	1,284	1,284	173,371	0	258,499	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,528	3,528	5,200	0	315,723	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	90,795	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,111	1,111	275,448	0	878,658	73.00
76.00	03950	DIABETIC SERVICES	1,229	0	88,625	0	137,346	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,665	15,665	3,270,859	0	5,917,628	88.00
91.00	09100	EMERGENCY	5,710	5,710	715,633	0	1,532,156	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	91,626	87,458	9,967,765	-5,960,887	17,541,300	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	4,529	0	947,404	0	1,437,945	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	632,060	808,654	3,524,662		5,960,887	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.573345	9.246198	0.322914		0.314074	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		629,560	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.033171	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/27/2016 2:39 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	86,303					6.00
7.00	00700	OPERATION OF PLANT	14,868	70,120				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	105,308			8.00
9.00	00900	HOUSEKEEPING	1,165	1,165	751	68,955		9.00
10.00	01000	DIETARY	6,598	6,598	0	6,598	53,052	10.00
11.00	01100	CAFETERIA	0	0	0	0	46,511	11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,623	2,623	0	2,623	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,602	10,602	42,911	10,602	6,541	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,363	5,363	10,843	5,363	0	50.00
53.00	05300	ANESTHESIOLOGY	231	231	0	231	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,018	5,018	15,946	5,018	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	1,900	1,900	90	1,900	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,248	3,248	9,097	3,248	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	281	281	0	281	0	67.00
68.00	06800	SPEECH PATHOLOGY	35	35	0	35	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,284	1,284	431	1,284	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,528	3,528	0	3,528	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,111	1,111	0	1,111	0	73.00
76.00	03950	DIABETIC SERVICES	1,229	1,229	0	1,229	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,665	15,665	0	15,665	0	88.00
91.00	09100	EMERGENCY	5,710	5,710	22,052	5,710	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	80,459	65,591	102,121	64,426	53,052	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,315	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,529	4,529	3,187	4,529	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	1,697,844	196,182	592,656	1,061,419	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	24.213406	1.862935	8.594823	20.007144	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	278,062	4,952	37,298	155,439	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	3.965516	0.047024	0.540903	2.929937	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/27/2016 2:39 pm

		Cost Center Description	CAFETERIA (FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)		
			11.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	7,365					11.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500	PHARMACY	0	0	0			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	500	0	0	60,527,706		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,755	0	0	2,458,279		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	720	0	0	3,071,381		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	896,833		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	893	0	0	4,716,564		54.00
56.00	05600	RADIOISOTOPE	40	0	0	982,854		56.00
57.00	05700	CT SCAN	0	0	0	5,957,303		57.00
58.00	05800	MRI	0	0	0	2,412,917		58.00
60.00	06000	LABORATORY	1,204	0	0	11,938,076		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	55	0	0	536,534		65.00
66.00	06600	PHYSICAL THERAPY	400	0	0	2,090,357		66.00
67.00	06700	OCCUPATIONAL THERAPY	100	0	0	538,943		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	186,552		68.00
69.00	06900	ELECTROCARDIOLOGY	284	0	0	2,563,372		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,381,326		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	309,497		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65	0	0	4,229,179		73.00
76.00	03950	DIABETIC SERVICES	80	0	0	32,828		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	494	0	0	7,562,929		88.00
91.00	09100	EMERGENCY	775	0	0	8,661,982		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,365	0	0	60,527,706		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	930,552	0	0	521,208		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	126.347862	0.000000	0.000000	0.008611		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	136,274	0	0	47,704		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	18.502919	0.000000	0.000000	0.000788		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/27/2016 2:39 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	2,708,482		2,708,482	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,269,830		1,269,830	0	0	50.00
53.00	05300	ANESTHESIOLOGY	95,841		95,841	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,610,023		1,610,023	0	0	54.00
56.00	05600	RADIOISOTOPE	231,783		231,783	0	0	56.00
57.00	05700	CT SCAN	455,907		455,907	0	0	57.00
58.00	05800	MRI	266,229		266,229	0	0	58.00
60.00	06000	LABORATORY	1,845,716		1,845,716	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	54,656	0	54,656	0	0	65.00
66.00	06600	PHYSICAL THERAPY	742,816	0	742,816	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	176,684	0	176,684	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	34,130	0	34,130	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	440,572		440,572	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	542,526		542,526	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	121,976		121,976	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,235,702		1,235,702	0	0	73.00
76.00	03950	DIABETIC SERVICES	231,195		231,195	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,417,682		8,417,682	0	0	88.00
91.00	09100	EMERGENCY	2,414,290		2,414,290	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	278,417		278,417		0	92.00
200.00		Subtotal (see instructions)	23,174,457	0	23,174,457	0	0	200.00
201.00		Less Observation Beds	278,417		278,417		0	201.00
202.00		Total (see instructions)	22,896,040	0	22,896,040	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/27/2016 2:39 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	2,104,345		2,104,345			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	159,675	2,911,706	3,071,381	0.413439	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	50,698	846,135	896,833	0.106866	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	153,953	4,562,611	4,716,564	0.341355	0.000000	54.00
56.00	05600	RADIOISOTOPE	21,319	961,535	982,854	0.235826	0.000000	56.00
57.00	05700	CT SCAN	239,644	5,717,659	5,957,303	0.076529	0.000000	57.00
58.00	05800	MRI	77,157	2,335,760	2,412,917	0.110335	0.000000	58.00
60.00	06000	LABORATORY	1,058,879	10,879,197	11,938,076	0.154607	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	435,714	100,820	536,534	0.101869	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	362,122	1,728,235	2,090,357	0.355354	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	145,834	393,109	538,943	0.327834	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	46,223	140,329	186,552	0.182952	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	203,388	2,359,984	2,563,372	0.171872	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	508,509	872,817	1,381,326	0.392757	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,716	300,781	309,497	0.394110	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,657,610	2,571,569	4,229,179	0.292185	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	32,828	32,828	7.042616	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,562,929	7,562,929			88.00
91.00	09100	EMERGENCY	224,932	8,437,050	8,661,982	0.278723	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	49,279	304,655	353,934	0.786635	0.000000	92.00
200.00		Subtotal (see instructions)	7,507,997	53,019,709	60,527,706			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,507,997	53,019,709	60,527,706			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/27/2016 2:39 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MRI	0.000000	58.00
60.00	06000	LABORATORY	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/27/2016 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,708,482		2,708,482	0	2,708,482	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,269,830		1,269,830	0	1,269,830	50.00
53.00	05300	ANESTHESIOLOGY	95,841		95,841	0	95,841	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,610,023		1,610,023	0	1,610,023	54.00
56.00	05600	RADIOISOTOPE	231,783		231,783	0	231,783	56.00
57.00	05700	CT SCAN	455,907		455,907	0	455,907	57.00
58.00	05800	MRI	266,229		266,229	0	266,229	58.00
60.00	06000	LABORATORY	1,845,716		1,845,716	0	1,845,716	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	54,656	0	54,656	0	54,656	65.00
66.00	06600	PHYSICAL THERAPY	742,816	0	742,816	0	742,816	66.00
67.00	06700	OCCUPATIONAL THERAPY	176,684	0	176,684	0	176,684	67.00
68.00	06800	SPEECH PATHOLOGY	34,130	0	34,130	0	34,130	68.00
69.00	06900	ELECTROCARDIOLOGY	440,572		440,572	0	440,572	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	542,526		542,526	0	542,526	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	121,976		121,976	0	121,976	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,235,702		1,235,702	0	1,235,702	73.00
76.00	03950	DIABETIC SERVICES	231,195		231,195	0	231,195	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,417,682		8,417,682	0	8,417,682	88.00
91.00	09100	EMERGENCY	2,414,290		2,414,290	0	2,414,290	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	278,417		278,417		278,417	92.00
200.00		Subtotal (see instructions)	23,174,457	0	23,174,457	0	23,174,457	200.00
201.00		Less Observation Beds	278,417		278,417		278,417	201.00
202.00		Total (see instructions)	22,896,040	0	22,896,040	0	22,896,040	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/27/2016 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,104,345		2,104,345			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	159,675	2,911,706	3,071,381	0.413439	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	50,698	846,135	896,833	0.106866	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	153,953	4,562,611	4,716,564	0.341355	0.000000	54.00
56.00	05600	RADIOISOTOPE	21,319	961,535	982,854	0.235826	0.000000	56.00
57.00	05700	CT SCAN	239,644	5,717,659	5,957,303	0.076529	0.000000	57.00
58.00	05800	MRI	77,157	2,335,760	2,412,917	0.110335	0.000000	58.00
60.00	06000	LABORATORY	1,058,879	10,879,197	11,938,076	0.154607	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	435,714	100,820	536,534	0.101869	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	362,122	1,728,235	2,090,357	0.355354	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	145,834	393,109	538,943	0.327834	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	46,223	140,329	186,552	0.182952	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	203,388	2,359,984	2,563,372	0.171872	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	508,509	872,817	1,381,326	0.392757	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,716	300,781	309,497	0.394110	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,657,610	2,571,569	4,229,179	0.292185	0.000000	73.00
76.00	03950	DIABETIC SERVICES	0	32,828	32,828	7.042616	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,562,929	7,562,929	1.113019	0.000000	88.00
91.00	09100	EMERGENCY	224,932	8,437,050	8,661,982	0.278723	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	49,279	304,655	353,934	0.786635	0.000000	92.00
200.00		Subtotal (see instructions)	7,507,997	53,019,709	60,527,706			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,507,997	53,019,709	60,527,706			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/27/2016 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.413439		50.00
53.00	05300	ANESTHESIOLOGY	0.106866		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.341355		54.00
56.00	05600	RADIOISOTOPE	0.235826		56.00
57.00	05700	CT SCAN	0.076529		57.00
58.00	05800	MRI	0.110335		58.00
60.00	06000	LABORATORY	0.154607		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.101869		65.00
66.00	06600	PHYSICAL THERAPY	0.355354		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.327834		67.00
68.00	06800	SPEECH PATHOLOGY	0.182952		68.00
69.00	06900	ELECTROCARDIOLOGY	0.171872		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.392757		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.394110		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.292185		73.00
76.00	03950	DIABETIC SERVICES	7.042616		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	1.113019		88.00
91.00	09100	EMERGENCY	0.278723		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.786635		92.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part II Date/Time Prepared: 2/27/2016 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,269,830	149,399	1,120,431	0	0	50.00
53.00	05300	ANESTHESIOLOGY	95,841	7,435	88,406	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,610,023	240,880	1,369,143	0	0	54.00
56.00	05600	RADIOISOTOPE	231,783	7,024	224,759	0	0	56.00
57.00	05700	CT SCAN	455,907	208,868	247,039	0	0	57.00
58.00	05800	MRI	266,229	8,097	258,132	0	0	58.00
60.00	06000	LABORATORY	1,845,716	139,501	1,706,215	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	54,656	2,529	52,127	0	0	65.00
66.00	06600	PHYSICAL THERAPY	742,816	89,398	653,418	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	176,684	9,179	167,505	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	34,130	1,327	32,803	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	440,572	41,969	398,603	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	542,526	83,271	459,255	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	121,976	3,256	118,720	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,235,702	56,265	1,179,437	0	0	73.00
76.00	03950	DIABETIC SERVICES	231,195	19,680	211,515	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,417,682	529,797	7,887,885	0	0	88.00
91.00	09100	EMERGENCY	2,414,290	189,088	2,225,202	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	278,417	56,592	221,825	0	0	92.00
200.00		Subtotal (sum of lines 50 thru 199)	20,465,975	1,843,555	18,622,420	0	0	200.00
201.00		Less Observation Beds	278,417	56,592	221,825	0	0	201.00
202.00		Total (line 200 minus line 201)	20,187,558	1,786,963	18,400,595	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part II Date/Time Prepared: 2/27/2016 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,269,830	3,071,381	0.413439		50.00
53.00	05300	ANESTHESIOLOGY	95,841	896,833	0.106866		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,610,023	4,716,564	0.341355		54.00
56.00	05600	RADIOISOTOPE	231,783	982,854	0.235826		56.00
57.00	05700	CT SCAN	455,907	5,957,303	0.076529		57.00
58.00	05800	MRI	266,229	2,412,917	0.110335		58.00
60.00	06000	LABORATORY	1,845,716	11,938,076	0.154607		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	54,656	536,534	0.101869		65.00
66.00	06600	PHYSICAL THERAPY	742,816	2,090,357	0.355354		66.00
67.00	06700	OCCUPATIONAL THERAPY	176,684	538,943	0.327834		67.00
68.00	06800	SPEECH PATHOLOGY	34,130	186,552	0.182952		68.00
69.00	06900	ELECTROCARDIOLOGY	440,572	2,563,372	0.171872		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	542,526	1,381,326	0.392757		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	121,976	309,497	0.394110		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,235,702	4,229,179	0.292185		73.00
76.00	03950	DIABETIC SERVICES	231,195	32,828	7.042616		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	8,417,682	7,562,929	1.113019		88.00
91.00	09100	EMERGENCY	2,414,290	8,661,982	0.278723		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	278,417	353,934	0.786635		92.00
200.00		Subtotal (sum of lines 50 thru 199)	20,465,975	58,423,361			200.00
201.00		Less Observation Beds	278,417	0			201.00
202.00		Total (line 200 minus line 201)	20,187,558	58,423,361			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/27/2016 2:39 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	149,399	3,071,381	0.048642	70,690	3,439	50.00
53.00	05300	ANESTHESIOLOGY	7,435	896,833	0.008290	22,215	184	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	240,880	4,716,564	0.051071	58,512	2,988	54.00
56.00	05600	RADIOISOTOPE	7,024	982,854	0.007147	14,862	106	56.00
57.00	05700	CT SCAN	208,868	5,957,303	0.035061	73,908	2,591	57.00
58.00	05800	MRI	8,097	2,412,917	0.003356	51,478	173	58.00
60.00	06000	LABORATORY	139,501	11,938,076	0.011685	423,945	4,954	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,529	536,534	0.004714	194,872	919	65.00
66.00	06600	PHYSICAL THERAPY	89,398	2,090,357	0.042767	68,360	2,924	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,179	538,943	0.017031	17,943	306	67.00
68.00	06800	SPEECH PATHOLOGY	1,327	186,552	0.007113	22,138	157	68.00
69.00	06900	ELECTROCARDIOLOGY	41,969	2,563,372	0.016373	98,915	1,620	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	83,271	1,381,326	0.060283	227,138	13,693	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,256	309,497	0.010520	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,265	4,229,179	0.013304	610,902	8,127	73.00
76.00	03950	DIABETIC SERVICES	19,680	32,828	0.599488	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	529,797	7,562,929	0.070052	0	0	88.00
91.00	09100	EMERGENCY	189,088	8,661,982	0.021830	24,740	540	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	56,592	353,934	0.159894	21,920	3,505	92.00
200.00		Total (lines 50-199)	1,843,555	58,423,361		2,002,538	46,226	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/27/2016 2:39 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/27/2016 2:39 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	3,071,381	0.000000	0.000000	70,690	50.00
53.00	05300	ANESTHESIOLOGY	0	896,833	0.000000	0.000000	22,215	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,716,564	0.000000	0.000000	58,512	54.00
56.00	05600	RADIOISOTOPE	0	982,854	0.000000	0.000000	14,862	56.00
57.00	05700	CT SCAN	0	5,957,303	0.000000	0.000000	73,908	57.00
58.00	05800	MRI	0	2,412,917	0.000000	0.000000	51,478	58.00
60.00	06000	LABORATORY	0	11,938,076	0.000000	0.000000	423,945	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	536,534	0.000000	0.000000	194,872	65.00
66.00	06600	PHYSICAL THERAPY	0	2,090,357	0.000000	0.000000	68,360	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	538,943	0.000000	0.000000	17,943	67.00
68.00	06800	SPEECH PATHOLOGY	0	186,552	0.000000	0.000000	22,138	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,563,372	0.000000	0.000000	98,915	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,381,326	0.000000	0.000000	227,138	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	309,497	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,229,179	0.000000	0.000000	610,902	73.00
76.00	03950	DIABETIC SERVICES	0	32,828	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,562,929	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	8,661,982	0.000000	0.000000	24,740	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	353,934	0.000000	0.000000	21,920	92.00
200.00		Total (lines 50-199)	0	58,423,361			2,002,538	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/27/2016 2:39 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	DIABETIC SERVICES	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/27/2016 2:39 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	0.413439	0	776,605	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.106866	0	201,834	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.341355	0	1,210,105	0	0	54.00
56.00	05600	RADIOISOTOPE	0.235826	0	291,035	0	0	56.00
57.00	05700	CT SCAN	0.076529	0	1,723,128	0	0	57.00
58.00	05800	MRI	0.110335	0	471,839	0	0	58.00
60.00	06000	LABORATORY	0.154607	0	3,546,657	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.101869	0	43,363	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.355354	0	530,245	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.327834	0	130,787	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.182952	0	40,689	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171872	0	879,990	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.392757	0	308,541	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.394110	0	92,506	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.292185	0	857,398	1,934	0	73.00
76.00	03950	DIABETIC SERVICES	7.042616	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.278723	0	2,283,852	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.786635	0	181,619	0	0	92.00
200.00		Subtotal (see instructions)		0	13,570,193	1,934	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	13,570,193	1,934	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/27/2016 2:39 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	321,079	0		50.00
53.00	05300	ANESTHESIOLOGY	21,569	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	413,075	0		54.00
56.00	05600	RADIOISOTOPE	68,634	0		56.00
57.00	05700	CT SCAN	131,869	0		57.00
58.00	05800	MRI	52,060	0		58.00
60.00	06000	LABORATORY	548,338	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	4,417	0		65.00
66.00	06600	PHYSICAL THERAPY	188,425	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	42,876	0		67.00
68.00	06800	SPEECH PATHOLOGY	7,444	0		68.00
69.00	06900	ELECTROCARDIOLOGY	151,246	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	121,182	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,458	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	250,519	565		73.00
76.00	03950	DIABETIC SERVICES	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	636,562	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	142,868	0		92.00
200.00		Subtotal (see instructions)	3,138,621	565		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,138,621	565		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141318 | Component CCN: 14Z318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/27/2016 2:39 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	0.413439	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.106866	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.341355	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.235826	0	0	0	0	56.00
57.00	05700	CT SCAN	0.076529	0	0	0	0	57.00
58.00	05800	MRI	0.110335	0	0	0	0	58.00
60.00	06000	LABORATORY	0.154607	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.101869	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.355354	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.327834	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.182952	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171872	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.392757	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.394110	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.292185	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	7.042616	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.278723	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.786635	0	0	0	0	92.00
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: 141318 | Component CCN: 14Z318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V | Date/Time Prepared: 2/27/2016 2:39 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03950	DIABETIC SERVICES	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part I | Date/Time Prepared: 2/27/2016 2:39 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	319,225	134,126	185,099	1,162	159.29	30.00
200.00	Total (lines 30-199)	319,225		185,099	1,162		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	108	17,203				30.00
200.00	Total (lines 30-199)	108	17,203				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/27/2016 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	149,399	3,071,381	0.048642	0	0	50.00
53.00	05300	ANESTHESIOLOGY	7,435	896,833	0.008290	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	240,880	4,716,564	0.051071	0	0	54.00
56.00	05600	RADIOISOTOPE	7,024	982,854	0.007147	0	0	56.00
57.00	05700	CT SCAN	208,868	5,957,303	0.035061	0	0	57.00
58.00	05800	MRI	8,097	2,412,917	0.003356	0	0	58.00
60.00	06000	LABORATORY	139,501	11,938,076	0.011685	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,529	536,534	0.004714	0	0	65.00
66.00	06600	PHYSICAL THERAPY	89,398	2,090,357	0.042767	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,179	538,943	0.017031	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,327	186,552	0.007113	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	41,969	2,563,372	0.016373	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	83,271	1,381,326	0.060283	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,256	309,497	0.010520	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	56,265	4,229,179	0.013304	0	0	73.00
76.00	03950	DIABETIC SERVICES	19,680	32,828	0.599488	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	529,797	7,562,929	0.070052	0	0	88.00
91.00	09100	EMERGENCY	189,088	8,661,982	0.021830	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	56,592	353,934	0.159894	0	0	92.00
200.00		Total (lines 50-199)	1,843,555	58,423,361		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part III Date/Time Prepared: 2/27/2016 2:39 pm

Title XIX | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,162	0.00	108	0		30.00
200.00		Total (lines 30-199)	1,162		108	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/27/2016 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03950	DIABETIC SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/27/2016 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,071,381	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	896,833	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,716,564	0.000000	0.000000	0	54.00
56.00	05600	RADIOISOTOPE	0	982,854	0.000000	0.000000	0	56.00
57.00	05700	CT SCAN	0	5,957,303	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	2,412,917	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	11,938,076	0.000000	0.000000	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	536,534	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,090,357	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	538,943	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	186,552	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,563,372	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,381,326	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	309,497	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,229,179	0.000000	0.000000	0	73.00
76.00	03950	DIABETIC SERVICES	0	32,828	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,562,929	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	8,661,982	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	353,934	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	58,423,361			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV Date/Time Prepared: 2/27/2016 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MRI	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03950	DIABETIC SERVICES	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/27/2016 2:39 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,004	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,162	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	956	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	210	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)	632	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	559	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)	147	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)	442	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,708,482	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,137,997	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,570,485	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,570,485	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,351.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	755,511	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	755,511	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/27/2016 2:39 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	494,880	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,250,391	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)	198,676	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	597,381	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	796,057	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)	206	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,351.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	278,417	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/27/2016 2:39 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	319,225	1,570,485	0.203265	278,417	56,592	90.00
91.00	Nursing School cost	0	1,570,485	0.000000	278,417	0	91.00
92.00	Allied health cost	0	1,570,485	0.000000	278,417	0	92.00
93.00	All other Medical Education	0	1,570,485	0.000000	278,417	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/27/2016 2:39 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,004	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,162	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	956	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	842	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	108	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,708,482	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,137,997	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,570,485	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,570,485	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,351.54	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	145,966	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	145,966	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/27/2016 2:39 pm

Title XIX | Hospital | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	145,966	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)	17,203	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)	17,203	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	128,763	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	206	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,351.54	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	278,417	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/27/2016 2:39 pm

Title XIX | Hospital | PPS

	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	319,225	1,570,485	0.203265	278,417	56,592	90.00
91.00	Nursing School cost	0	1,570,485	0.000000	278,417	0	91.00
92.00	Allied health cost	0	1,570,485	0.000000	278,417	0	92.00
93.00	All other Medical Education	0	1,570,485	0.000000	278,417	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/27/2016 2:39 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		812,620		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.413439	70,690	29,226	50.00
53.00	05300	ANESTHESIOLOGY	0.106866	22,215	2,374	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.341355	58,512	19,973	54.00
56.00	05600	RADIOISOTOPE	0.235826	14,862	3,505	56.00
57.00	05700	CT SCAN	0.076529	73,908	5,656	57.00
58.00	05800	MRI	0.110335	51,478	5,680	58.00
60.00	06000	LABORATORY	0.154607	423,945	65,545	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.101869	194,872	19,851	65.00
66.00	06600	PHYSICAL THERAPY	0.355354	68,360	24,292	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.327834	17,943	5,882	67.00
68.00	06800	SPEECH PATHOLOGY	0.182952	22,138	4,050	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171872	98,915	17,001	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.392757	227,138	89,210	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.394110	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.292185	610,902	178,496	73.00
76.00	03950	DIABETIC SERVICES	7.042616	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.278723	24,740	6,896	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.786635	21,920	17,243	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,002,538	494,880	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)		2,002,538		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141318 | Component CCN: 14Z318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/27/2016 2:39 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.413439	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.106866	12,555	1,342	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.341355	0	0	54.00
56.00	05600	RADIOISOTOPE	0.235826	1,927	454	56.00
57.00	05700	CT SCAN	0.076529	8,956	685	57.00
58.00	05800	MRI	0.110335	7,790	860	58.00
60.00	06000	LABORATORY	0.154607	138,718	21,447	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.101869	90,381	9,207	65.00
66.00	06600	PHYSICAL THERAPY	0.355354	204,854	72,796	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.327834	86,772	28,447	67.00
68.00	06800	SPEECH PATHOLOGY	0.182952	11,828	2,164	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171872	11,860	2,038	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.392757	59,759	23,471	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.394110	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.292185	282,112	82,429	73.00
76.00	03950	DIABETIC SERVICES	7.042616	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.278723	58	16	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.786635	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		917,570	245,356	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)		917,570		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/27/2016 2:39 pm

Title XIX | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.413439	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.106866	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.341355	0	0	54.00
56.00	05600	RADIOISOTOPE	0.235826	0	0	56.00
57.00	05700	CT SCAN	0.076529	0	0	57.00
58.00	05800	MRI	0.110335	0	0	58.00
60.00	06000	LABORATORY	0.154607	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.101869	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.355354	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.327834	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.182952	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.171872	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.392757	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.394110	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.292185	0	0	73.00
76.00	03950	DIABETIC SERVICES	7.042616	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.113019	0	0	88.00
91.00	09100	EMERGENCY	0.278723	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.786635	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		0	0	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)		0		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141318	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/27/2016 2:39 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,139,186	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,139,186	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,170,578	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	20,733	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,990,866	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,158,979	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,158,979	30.00
31.00	Primary payer payments	399	31.00
32.00	Subtotal (line 30 minus line 31)	1,158,580	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)	104,365	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	67,837	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	1,226,417	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,226,417	40.00
40.01	Sequestration adjustment (see instructions)	24,528	40.01
41.00	Interim payments	1,336,117	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-134,228	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: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I Date/Time Prepared: 2/27/2016 2:39 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		1,180,362		1,639,577	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	05/05/2015	115,500		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	09/22/2015	149,647	05/05/2015	332	3.50
3.51			0	09/22/2015	303,128	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)		-34,147		-303,460	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)		1,146,215		1,336,117	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		80,155		134,228	6.02
7.00	Total Medicare program liability (see instructions)		1,066,060		1,201,889	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: 141318 | Component CCN: 14Z318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2016 2:39 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,130,553		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	05/05/2015	86,860		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	09/22/2015	124,606		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)		-37,746		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)		1,092,807		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		65,942		0	6.02
7.00	Total Medicare program liability (see instructions)		1,026,865		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: 141318	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/27/2016 2:39 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	308	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	559	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	102	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	956	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	60,527,706	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,435,456	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1	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)	1	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141318 | Component CCN: 14Z318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-2 | Date/Time Prepared: 2/27/2016 2:39 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)	804,018	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)	247,810	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	589	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)	1,051,828	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,051,828	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)	1,051,828	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,007	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)	1,047,821	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)	1,047,821	0	19.00
19.01	Sequestration adjustment (see instructions)	20,956	0	19.01
20.00	Interim payments	1,092,807	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)	-65,942	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: 141318	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part V Date/Time Prepared: 2/27/2016 2:39 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,250,391	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)	1,250,391	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,262,895	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)	1,262,895	19.00
20.00	Deductibles (exclude professional component)	188,808	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,074,087	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,074,087	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	21,122	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	13,729	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,087,816	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)	1,087,816	30.00
30.01	Sequestration adjustment (see instructions)	21,756	30.01
31.00	Interim payments	1,146,215	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)	-80,155	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: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/27/2016 2:39 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	9,732,601	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	13,256,070	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,505,270	0	0	0	6.00
7.00	Inventory	425,581	0	0	0	7.00
8.00	Prepaid expenses	33,864	0	0	0	8.00
9.00	Other current assets	677,953	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)	15,620,799	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	325,000	0	0	0	12.00
13.00	Land improvements	188,447	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	9,788,364	0	0	0	15.00
16.00	Accumulated depreciation	-3,036,445	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	-165,418	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	7,210,266	0	0	0	23.00
24.00	Accumulated depreciation	-3,961,013	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	3,601,560	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13,950,761	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	2,479,638	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	7,121,646	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,601,284	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	39,172,844	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,234,524	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2,244,130	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	883,362	0	0	0	43.00
44.00	Other current liabilities	415,354	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	4,777,370	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	189,861	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	189,861	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	4,967,231	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	34,205,613				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)	34,205,613	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	39,172,844	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 2/27/2016 2:39 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		27,280,391		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,095,074				2.00
3.00	Total (sum of line 1 and line 2)		32,375,465		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	INCREASE IN TEMP. RESTRICTED ASSETS	2,230,148		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)		2,230,148		0		10.00
11.00	Subtotal (line 3 plus line 10)		34,605,613		0		11.00
12.00	CONTRIBUTIONS RELEASED	400,000		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)		400,000		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		34,205,613		0		19.00

		Endowment Fund	Plant Fund		
		6.00	7.00	8.00	
1.00	Fund balances at beginning of period	0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)				2.00
3.00	Total (sum of line 1 and line 2)	0		0	3.00
4.00	Additions (credit adjustments) (specify)		0		4.00
5.00	INCREASE IN TEMP. RESTRICTED ASSETS		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	CONTRIBUTIONS RELEASED		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: 141318 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/27/2016 2:39 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,104,345		2,104,345	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)	2,104,345		2,104,345	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,104,345		2,104,345	17.00
18.00	Ancillary services	5,403,652	45,451,827	50,855,479	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	7,562,929	7,562,929	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)- PROFESSOINAL FEES	114,922	5,933,477	6,048,399	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,622,919	58,948,233	66,571,152	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,315,694		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		27,315,694		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141318	Period: From 10/01/2014 To 09/30/2015	Worksheet G-3 Date/Time Prepared: 2/27/2016 2:39 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	66,571,152	1.00
2.00	Less contractual allowances and discounts on patients' accounts	36,263,742	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,307,410	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,315,694	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,991,716	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	641,395	6.00
7.00	Income from investments	36,738	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	25,056	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	8,077	16.00
17.00	Revenue from sale of drugs to other than patients	1,066,393	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	2,201	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER GRANT INCOME	323,498	24.00
25.00	Total other income (sum of lines 6-24)	2,103,358	25.00
26.00	Total (line 5 plus line 25)	5,095,074	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,095,074	29.00

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

Provider CCN: 141318 Component CCN: 143461 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/27/2016 2:39 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	1,675,346	387,085	2,062,431	-390,835	1,671,596	1.00
2.00	Physician Assistant	380,358	87,881	468,239	-88,733	379,506	2.00
3.00	Nurse Practitioner	86,255	19,929	106,184	-20,122	86,062	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	574,152	132,656	706,808	-133,941	572,867	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	52,890	12,220	65,110	-12,338	52,772	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	197,798	45,701	243,499	-46,143	197,356	9.00
10.00	Subtotal (sum of lines 1 through 9)	2,966,799	685,472	3,652,271	-692,112	2,960,159	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	32,658	32,658	-19,291	13,367	15.00
16.00	Transportation (Health Care Staff)	0	13,253	13,253	0	13,253	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	63,972	63,972	0	63,972	18.00
19.00	Other Health Care Costs	0	1,214,358	1,214,358	0	1,214,358	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,324,241	1,324,241	-19,291	1,304,950	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,966,799	2,009,713	4,976,512	-711,403	4,265,109	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	152,481	152,481	-152,481	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	152,481	152,481	-152,481	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	305,017	373,476	678,493	-324,767	353,726	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	305,017	373,476	678,493	-324,767	353,726	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,271,816	2,535,670	5,807,486	-1,188,651	4,618,835	32.00

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

Provider CCN: 141318 Component CCN: 143461 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/27/2016 2:39 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	1,671,596		1.00
2.00	Physician Assistant	0	379,506		2.00
3.00	Nurse Practitioner	0	86,062		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	572,867		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	52,772		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	197,356		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,960,159		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	13,367		15.00
16.00	Transportation (Health Care Staff)	0	13,253		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	63,972		18.00
19.00	Other Health Care Costs	0	1,214,358		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	1,304,950		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	4,265,109		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	0		29.00
30.00	Administrative Costs	-5,228	348,498		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-5,228	348,498		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-5,228	4,613,607		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES | Provider CCN: 141318 | Component CCN: 143461 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-2 | Date/Time Prepared: 2/27/2016 2:39 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	5.83	21,669	4,200	24,486		1.00
2.00	Physician Assistant	3.66	12,968	2,100	7,686		2.00
3.00	Nurse Practitioner	0.86	3,031	2,100	1,806		3.00
4.00	Subtotal (sum of lines 1 through 3)	10.35	37,668		33,978	37,668	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	0.98	1,013			1,013	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)	11.33	38,681			38,681	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)	4,265,109	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)	4,265,109	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)	348,498	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	3,804,075	15.00
16.00	Total overhead (sum of lines 14 and 15)	4,152,573	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	4,152,573	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	4,152,573	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	8,417,682	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141318 Component CCN: 143461	Period: From 10/01/2014 To 09/30/2015	Worksheet M-3 Date/Time Prepared: 2/27/2016 2:39 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)		8,417,682	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		173,059	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		8,244,623	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		38,681	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)		38,681	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		213.14	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)	213.14	213.14	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	1,723	5,167	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	367,240	1,101,294	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) *		1,468,534	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,373,643	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		2,545	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		2,721	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.)		1,090,648	16.04
16.05	Total program cost (see instructions)		1,093,369	16.05
17.00	Primary payer amounts		1,637	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		102,503	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		253,719	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,091,732	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		65,939	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,157,671	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		1,157,671	26.00
26.01	Sequestration adjustment (see instructions)		23,153	26.01
27.00	Interim payments		1,221,445	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)		-86,927	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: 141318 | Component CCN: 143461 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-4 | Date/Time Prepared: 2/27/2016 2:39 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)	2,960,159	2,960,159	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.002097	0.006174	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	6,207	18,276	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	39,279	23,924	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	45,486	42,200	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	4,265,109	4,265,109	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	4,152,573	4,152,573	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.010665	0.009894	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	44,287	41,086	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	89,773	83,286	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	542	1,596	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	165.63	52.18	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	268	413	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	44,389	21,550	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)		173,059	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)		65,939	16.00

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

Provider CCN: 141318 Component CCN: 143461 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-5 | Date/Time Prepared: 2/27/2016 2:39 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		928,813	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		05/05/2015	53,020	3.01
3.02		09/22/2015	239,612	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)		292,632	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,221,445	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		86,927	6.02
7.00	Total Medicare program liability (see instructions)		1,134,518	7.00

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