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: 141319	Period: From 06/01/2014 To 05/31/2015	Worksheet S Parts I-III Date/Time Prepared: 10/19/2015 3:25 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 10/19/2015 Time: 3:25 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 HAMMOND-HENRY HOSPITAL (141319) for the cost reporting period beginning 06/01/2014 and ending 05/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	86,990	30,694	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	14,581	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
200.00	Total	0	101,571	30,694	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 10/17/2015 11:48 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 600 N. COLLEGE AVENUE	PO Box:			1.00
2.00	City: GENESEO	State: IL	Zip Code: 61254-1099	County: HENRY	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	HAMMOND-HENRY HOSPITAL	141319	19340	1	06/04/2002	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	HAMMOND-HENRY SWING BED	14Z319	19340		05/21/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	HAMMOND-HENRY SKILLED NURSING	145464	19340		06/01/1983	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	HAMMOND-HENRY HOME HEALTH SERVICES	147450	19340		06/05/1986	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
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)	06/01/2014	05/31/2015	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
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: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 10/17/2015 11:48 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 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: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 10/17/2015 11:48 am

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141319	Period: From 06/01/2014 To 05/31/2015	Worksheet S-2 Part I Date/Time Prepared: 10/17/2015 11:48 am

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (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, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141319	Period: From 06/01/2014 To 05/31/2015	Worksheet S-2 Part I Date/Time Prepared: 10/17/2015 11:48 am

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	Y	N	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/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: 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 would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	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, §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:	430,281	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 10/17/2015 11:48 am

		1.00	2.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
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, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
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
161.10	CORF		N	N	N	161.10

		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 Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141319	Period: From 06/01/2014 To 05/31/2015	Worksheet S-2 Part I Date/Time Prepared: 10/17/2015 11:48 am

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2014	09/30/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 10/17/2015 11:48 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		Y		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been 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
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	09/08/2015	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 10/17/2015 11:48 am

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404	DAN.LINHART@MCGLADREY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 10/17/2015 11:48 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	09/08/2015			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 10/17/2015 11:48 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	93,384.00	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)		25	9,125	93,384.00	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	43.00				0	13.00
14.00	Total (see instructions)		25	9,125	93,384.00	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	44.00	37	13,505		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	0	0			21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
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)		62				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: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 10/17/2015 11:48 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,972	302	3,785			1.00
2.00	HMO and other (see instructions)	237	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	341	0	423			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	30			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,313	302	4,238			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		178	450			13.00
14.00	Total (see instructions)	2,313	480	4,688	0.00	202.05	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	1,023	0	12,579	0.00	23.58	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY	8,698	0	11,302	0.00	9.08	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
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	234.71	27.00
28.00	Observation Bed Days		0	576			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)			106			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 10/17/2015 11:48 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	617	250	1,365	1.00
2.00	HMO and other (see instructions)			73	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						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	617	250	1,365	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	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
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

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 141319 | Component CCN: 147450 | Period: From 06/01/2014 To 05/31/2015 | Worksheet S-4 | Date/Time Prepared: 10/17/2015 11:48 am

Home Health Agency I | PPS

					1.00		
0.00	County				HENRY		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	14,762	0	0	14,762	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	259.00	0.00	0.00	259.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.98	0.00	0.98	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			1.00	0.00	1.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			7.10	0.00	7.10	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			5			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			19340			20.00
20.01				37900			20.01
20.02				99914			20.02
20.03				50208			20.03
20.04				49740			20.04
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	4,129	312	155	78	4,674	21.00
22.00	Skilled Nursing Visit Charges	514,845	41,101	15,143	9,734	580,823	22.00
23.00	Physical Therapy Visits	1,331	64	8	33	1,436	23.00
24.00	Physical Therapy Visit Charges	223,013	10,701	1,189	5,605	240,508	24.00
25.00	Occupational Therapy Visits	870	63	5	15	953	25.00
26.00	Occupational Therapy Visit Charges	146,750	10,701	849	2,548	160,848	26.00
27.00	Speech Pathology Visits	163	14	0	0	177	27.00
28.00	Speech Pathology Visit Charges	27,346	2,378	0	0	29,724	28.00
29.00	Medical Social Service Visits	7	6	0	0	13	29.00
30.00	Medical Social Service Visit Charges	1,456	1,248	0	0	2,704	30.00
31.00	Home Health Aide Visits	1,280	139	7	19	1,445	31.00
32.00	Home Health Aide Visit Charges	90,127	9,901	437	1,310	101,775	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	7,780	598	175	145	8,698	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,003,537	76,030	17,618	19,197	1,116,382	35.00
36.00	Total Number of Episodes (standard/non outlier)	374		45	6	425	36.00
37.00	Total Number of Outlier Episodes		12		1	13	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet S-7 | Date/Time Prepared: 10/17/2015 11:48 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	05/21/2003	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	30	0	30	13.00
14.00		RUA	65	0	65	14.00
15.00		RVC	62	0	62	15.00
16.00		RVB	146	0	146	16.00
17.00		RVA	346	0	346	17.00
18.00		RHC	30	0	30	18.00
19.00		RHB	82	0	82	19.00
20.00		RHA	168	0	168	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	10	0	10	22.00
23.00		RMA	46	0	46	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	3	0	3	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	11	0	11	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	4	0	4	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet S-7 | Date/Time Prepared: 10/17/2015 11:48 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	12	0	12	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	8	0	8	78.00
199.00		AAA	0	419	419	199.00
200.00	TOTAL		1,023	419	1,442	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914	99914	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	758,359	32.29	Y	202.00
203.00	Recruitment	0	0.00	N	203.00
204.00	Retention of employees	0	0.00	N	204.00
205.00	Training	3,905	0.17	N	205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	2,348,226			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet S-10 | Date/Time Prepared: 10/17/2015 11:48 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.418003	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,198,923	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	964,462	5.00
6.00	Medicaid charges	4,066,450	6.00
7.00	Medicaid cost (line 1 times line 6)	1,699,788	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	82,913	269,883	352,796	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	34,658	112,812	147,470	21.00
22.00	Partial payment by patients approved for charity care	749	46,473	47,222	22.00
23.00	Cost of charity care (line 21 minus line 22)	33,909	66,339	100,248	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)	1,109,455	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	98,434	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,011,021	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	422,610	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	522,858	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	522,858	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet A | Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,093,933	2,093,933	925,979	3,019,912	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,349,349	1,349,349	16,165	1,365,514	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	80,648	3,887,675	3,968,323	0	3,968,323	4.00
5.01	00550	DATA PROCESSING	358,413	315,704	674,117	0	674,117	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	114,436	3,725	118,161	0	118,161	5.02
5.03	00570	ADMITTING	155,792	40,462	196,254	0	196,254	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	274,979	234,256	509,235	-78,478	430,757	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	440,696	1,899,866	2,340,562	2,866	2,343,428	5.05
7.00	00700	OPERATION OF PLANT	191,427	909,626	1,101,053	0	1,101,053	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,132	113,028	144,160	0	144,160	8.00
9.00	00900	HOUSEKEEPING	341,522	99,783	441,305	0	441,305	9.00
10.00	01000	DIETARY	437,050	427,405	864,455	0	864,455	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	264,915	29,664	294,579	0	294,579	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,288	26,288	0	26,288	14.00
15.00	01500	PHARMACY	203,962	159,567	363,529	0	363,529	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	343,864	69,525	413,389	0	413,389	16.00
17.00	01700	SOCIAL SERVICE	124,637	2,429	127,066	0	127,066	17.00
18.00	01080	INSERVICE EDUCATION	101,551	21,482	123,033	0	123,033	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,015,521	205,325	2,220,846	-142,493	2,078,353	30.00
43.00	04300	NURSERY	0	1,582	1,582	58,942	60,524	43.00
44.00	04400	SKILLED NURSING FACILITY	794,775	80,785	875,560	0	875,560	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,296,615	2,393,383	3,689,998	-1,153,757	2,536,241	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	83,551	83,551	52.00
53.00	05300	ANESTHESIOLOGY	691,089	120,395	811,484	-120,395	691,089	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	682,519	1,277,655	1,960,174	16,254	1,976,428	54.00
60.00	06000	LABORATORY	603,836	819,670	1,423,506	0	1,423,506	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	136,703	136,703	0	136,703	62.00
64.00	06400	INTRAVENOUS THERAPY	2,187	3,545	5,732	0	5,732	64.00
66.00	06600	PHYSICAL THERAPY	1,109,142	89,856	1,198,998	0	1,198,998	66.00
67.00	06700	OCCUPATIONAL THERAPY	380,729	21,862	402,591	0	402,591	67.00
68.00	06800	SPEECH PATHOLOGY	77,487	7,567	85,054	0	85,054	68.00
69.00	06900	ELECTROCARDIOLOGY	225,279	189,424	414,703	0	414,703	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	1,274,152	1,274,152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	830,899	830,899	0	830,899	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	52,162	47,800	99,962	0	99,962	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	603,602	224,422	828,024	38,958	866,982	90.00
90.01	09001	OB CLINIC	269,630	22,302	291,932	0	291,932	90.01
90.02	09002	SPECIALTY CLINIC	614	27,038	27,652	0	27,652	90.02
90.03	09003	SURGICAL CLINIC	1,620	466,091	467,711	0	467,711	90.03
91.00	09100	EMERGENCY	505,615	1,479,398	1,985,013	0	1,985,013	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	502,381	121,554	623,935	0	623,935	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		921,744	921,744	-921,744	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,279,827	21,172,767	34,452,594	0	34,452,594	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
192.01	19203	MUSCATINE CLINIC	149	200,780	200,929	0	200,929	192.01
192.02	19201	CARDIOLOGY CLINIC	0	3,822	3,822	0	3,822	192.02
192.03	19202	LEASED SPACE	6,813	65,688	72,501	0	72,501	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
200.00		TOTAL (SUM OF LINES 118-199)	13,286,789	21,443,057	34,729,846	0	34,729,846	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet A | Date/Time Prepared: 10/17/2015 11:48 am

		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	42,469	3,062,381		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-313,540	1,051,974		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-298,674	3,669,649		4.00
5.01	00550	DATA PROCESSING	0	674,117		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	-6,170	111,991		5.02
5.03	00570	ADMITTING	0	196,254		5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	430,757		5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	-172,930	2,170,498		5.05
7.00	00700	OPERATION OF PLANT	0	1,101,053		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	144,160		8.00
9.00	00900	HOUSEKEEPING	0	441,305		9.00
10.00	01000	DIETARY	-188,160	676,295		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	294,579		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,288		14.00
15.00	01500	PHARMACY	0	363,529		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-914	412,475		16.00
17.00	01700	SOCIAL SERVICE	0	127,066		17.00
18.00	01080	INSERVICE EDUCATION	0	123,033		18.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	2,078,353		30.00
43.00	04300	NURSERY	0	60,524		43.00
44.00	04400	SKILLED NURSING FACILITY	300	875,860		44.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-3,500	2,532,741		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	83,551		52.00
53.00	05300	ANESTHESIOLOGY	-691,089	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-16,254	1,960,174		54.00
60.00	06000	LABORATORY	0	1,423,506		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	136,703		62.00
64.00	06400	INTRAVENOUS THERAPY	0	5,732		64.00
66.00	06600	PHYSICAL THERAPY	-116,264	1,082,734		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	402,591		67.00
68.00	06800	SPEECH PATHOLOGY	0	85,054		68.00
69.00	06900	ELECTROCARDIOLOGY	-28,572	386,131		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,274,152		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	830,899		73.00
76.00	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	99,962		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	-495,185	371,797		90.00
90.01	09001	OB CLINIC	-253,327	38,605		90.01
90.02	09002	SPECIALTY CLINIC	-22,000	5,652		90.02
90.03	09003	SURGICAL CLINIC	-255,718	211,993		90.03
91.00	09100	EMERGENCY	-481,422	1,503,591		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	-2,662	621,273		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,303,612	31,148,982		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19203	MUSCATINE CLINIC	0	200,929		192.01
192.02	19201	CARDIOLOGY CLINIC	0	3,822		192.02
192.03	19202	LEASED SPACE	0	72,501		192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0		194.02
194.03	07952	ANESTHESIA BILLNG	0	0		194.03
194.04	07953	SPECIALTY CLINIC	0	0		194.04
194.05	07954	COLONA CLINIC	0	0		194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0		194.06
200.00		TOTAL (SUM OF LINES 118-199)	-3,303,612	31,426,234		200.00

RECLASSIFICATIONS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet A-6 | Date/Time Prepared: 10/17/2015 11:48 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - COLONA CLINIC BUILDING DEPRECIATION					
1.00	CLINIC	90.00	0	38,958		1.00
	TOTALS		0	38,958		
	C - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	902,624		1.00
	TOTALS		0	902,624		
	D - CAPITAL LEASE INTEREST					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	2,866		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	16,254		2.00
	TOTALS		0	19,120		
	E - OTHER CAPITAL COSTS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	62,313		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	16,165		2.00
	TOTALS		0	78,478		
	F - DELIVERY AND LABOR RECLASS					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	83,551	0		1.00
	TOTALS		83,551	0		
	G - RECLASS ALLOWABLE ANESTHESIA EXPENSE					
1.00	OPERATING ROOM	50.00	0	120,395		1.00
	TOTALS		0	120,395		
	H - IMPLANT EXP RECLASS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,274,152		1.00
	TOTALS		0	1,274,152		
	I - NURSERY RECLASS					
1.00	NURSERY	43.00	58,942	0		1.00
	TOTALS		58,942	0		
500.00	Grand Total: Increases		142,493	2,433,727		500.00

RECLASSIFICATIONS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet A-6 | Date/Time Prepared: 10/17/2015 11:48 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - COLONA CLINIC BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	38,958	9		1.00
	TOTALS		0	38,958			
	C - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	902,624	11		1.00
	TOTALS		0	902,624			
	D - CAPITAL LEASE INTEREST						
1.00	INTEREST EXPENSE	113.00	0	19,120	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	19,120			
	E - OTHER CAPITAL COSTS						
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.04	0	78,478	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	78,478			
	F - DELIVERY AND LABOR RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	83,551	0	0		1.00
	TOTALS		83,551	0			
	G - RECLASS ALLOWABLE ANESTHESIA EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	120,395	0		1.00
	TOTALS		0	120,395			
	H - IMPLANT EXP RECLASS						
1.00	OPERATING ROOM	50.00	0	1,274,152	0		1.00
	TOTALS		0	1,274,152			
	I - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	58,942	0	0		1.00
	TOTALS		58,942	0			
500.00	Grand Total: Decreases		142,493	2,433,727			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 10/17/2015 11:48 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,269,519	30,140	0	30,140	0	1.00
2.00	Land Improvements	1,332,530	38,495	0	38,495	0	2.00
3.00	Buildings and Fixtures	44,509,979	202,726	0	202,726	0	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	11,664,408	1,003,739	0	1,003,739	375,745	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	58,776,436	1,275,100	0	1,275,100	375,745	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	58,776,436	1,275,100	0	1,275,100	375,745	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,299,659	0	1.00
2.00	Land Improvements	1,371,025	0	2.00
3.00	Buildings and Fixtures	44,712,705	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	12,292,402	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	59,675,791	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	59,675,791	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet A-7 Part II Date/Time Prepared: 10/17/2015 11:48 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,093,933	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1,349,349	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,443,282	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	2,093,933	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,349,349	2.00
3.00	Total (sum of lines 1-2)	0	3,443,282	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 10/17/2015 11:48 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	47,383,389	0	47,383,389	0.794014	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	12,292,402	0	12,292,402	0.205986	0	2.00
3.00	Total (sum of lines 1-2)	59,675,791	0	59,675,791	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,054,975	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,035,809	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,090,784	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	945,093	62,313	0	0	3,062,381	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	16,165	0	0	1,051,974	2.00
3.00	Total (sum of lines 1-2)	945,093	78,478	0	0	4,114,355	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet A-8 | Date/Time Prepared: 10/17/2015 11:48 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,539,724			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet A-8 | Date/Time Prepared: 10/17/2015 11:48 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-311,696	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CAFETERIA-EMPLOYEES AND GUESTS	B	-180,319	DIETARY	10.00	0	33.00
33.01	SALE OF MEDICAL RECORDS AND ABSTRACT	B	-914	MEDICAL RECORDS & LIBRARY	16.00	0	33.01
33.02	VENDING MACHINES	B	-123	DIETARY	10.00	0	33.02
33.03	DIETARY RECEIPTS - OTHER	B	-7,718	DIETARY	10.00	0	33.03
33.04	SUPPLIES REBATES	B	-6,099	PURCHASING RECEIVING AND STORES	5.02	0	33.04
33.05	ATHLETIC TRAINING REVENUE	B	-25,948	PHYSICAL THERAPY	66.00	0	33.05
33.06	A/P REVENUE	B	-71	PURCHASING RECEIVING AND STORES	5.02	0	33.06
33.07	PHYSICAL THERAPY TO SUMMIT	B	-77,589	PHYSICAL THERAPY	66.00	0	33.07
33.08	PT OUTREACH REVENUE	A	-12,727	PHYSICAL THERAPY	66.00	0	33.08
33.09	LIFELINE REVENUE	B	-2,662	HOME HEALTH AGENCY	101.00	0	33.09
33.10	FOUNDATION EXPENSES	B	-95,101	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.10
33.11	ADVERTISING EXPENSE	B	-73,717	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.11
33.12	CRNA EXPENSE	B	-691,089	ANESTHESIOLOGY	53.00	0	33.12
33.13	CRNA FRINGES	B	-155,570	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.13
33.14	LTC OTHER REVENUE	B	300	SKILLED NURSING FACILITY	44.00	0	33.14
33.15	CABLE TV	A	-1,844	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.15
33.16	TELEPHONE SERVICES	A	-1,246	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.16
33.17	UNNECESSARY BORROWING - CAP LEASE	A	-2,866	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.17
33.18	UNNECESSARY BORROWING - CAP LEASE	A	-16,254	RADIOLOGY-DIAGNOSTIC	54.00	0	33.18
33.19	PHYSICIAN BENEFIT OFFSET	A	-143,104	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.19
33.21	UNAMMORTIZED BOND ISSUE COST	B	31,790	CAP REL COSTS-BLDG & FIXT	1.00	11	33.21
33.23	UNAMMORTIZED BOND ISSUE COST	B	10,679	CAP REL COSTS-BLDG & FIXT	1.00	11	33.23
33.25			0		0.00	0	33.25
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,303,612				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 10/17/2015 11:48 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	43,918	0	43,918	0	0	1.00
2.00	91.00	EMERGENCY	1,362,170	481,422	880,748	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	28,572	28,572	0	0	0	3.00
4.00	90.00	CLINIC	382,385	382,385	0	0	0	4.00
5.00	90.00	CLINIC	112,800	112,800	0	0	0	5.00
6.00	90.01	OB CLINIC	253,327	253,327	0	0	0	6.00
7.00	90.02	SPECIALTY CLINIC	22,000	22,000	0	0	0	7.00
8.00	90.03	SURGICAL CLINIC	255,718	255,718	0	0	0	8.00
9.00	50.00	OPERATING ROOM	3,500	3,500	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,464,390	1,539,724	924,666		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	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	90.00	CLINIC	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.01	OB CLINIC	0	0	0	0	0	6.00
7.00	90.02	SPECIALTY CLINIC	0	0	0	0	0	7.00
8.00	90.03	SURGICAL CLINIC	0	0	0	0	0	8.00
9.00	50.00	OPERATING ROOM	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	60.00	LABORATORY	0	0	0	0		1.00
2.00	91.00	EMERGENCY	0	0	0	481,422		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	28,572		3.00
4.00	90.00	CLINIC	0	0	0	382,385		4.00
5.00	90.00	CLINIC	0	0	0	112,800		5.00
6.00	90.01	OB CLINIC	0	0	0	253,327		6.00
7.00	90.02	SPECIALTY CLINIC	0	0	0	22,000		7.00
8.00	90.03	SURGICAL CLINIC	0	0	0	255,718		8.00
9.00	50.00	OPERATING ROOM	0	0	0	3,500		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,539,724		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B Part I Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,062,381	3,062,381				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,051,974		1,051,974			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,669,649	14,596	0	3,684,245		4.00
5.01	00550	DATA PROCESSING	674,117	60,725	91,231	111,956	938,029	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	111,991	65,506	0	35,746	6,093	5.02
5.03	00570	ADMITTING	196,254	26,167	0	48,664	22,874	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	430,757	24,387	226	85,894	0	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	2,170,498	69,346	12,831	111,208	122,972	5.05
7.00	00700	OPERATION OF PLANT	1,101,053	180,752	24,802	59,795	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	144,160	19,479	1,473	9,725	0	8.00
9.00	00900	HOUSEKEEPING	441,305	33,948	0	106,680	652	9.00
10.00	01000	DIETARY	676,295	77,229	6,285	136,519	5,213	10.00
11.00	01100	CAFETERIA	0	50,299	0	0	978	11.00
13.00	01300	NURSING ADMINISTRATION	294,579	21,361	687	82,750	11,404	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26,288	2,696	0	0	0	14.00
15.00	01500	PHARMACY	363,529	31,278	3,803	63,711	15,966	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	412,475	35,321	3,327	107,411	82,926	16.00
17.00	01700	SOCIAL SERVICE	127,066	8,570	39	38,932	7,657	17.00
18.00	01080	INSERVICE EDUCATION	123,033	23,548	4,777	31,721	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,078,353	289,717	90,540	585,075	184,070	30.00
43.00	04300	NURSERY	60,524	5,849	6,414	18,411	0	43.00
44.00	04400	SKILLED NURSING FACILITY	875,860	373,049	37,522	248,260	44,379	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,532,741	305,763	220,083	405,017	83,252	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	83,551	2,619	0	26,098	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,960,174	189,525	363,827	213,195	42,620	54.00
60.00	06000	LABORATORY	1,423,506	59,301	54,139	188,617	35,256	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	136,703	1,958	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	5,732	4,323	0	683	0	64.00
66.00	06600	PHYSICAL THERAPY	1,082,734	196,264	28,312	346,457	25,578	66.00
67.00	06700	OCCUPATIONAL THERAPY	402,591	74,711	0	118,926	3,584	67.00
68.00	06800	SPEECH PATHOLOGY	85,054	12,969	0	24,204	1,629	68.00
69.00	06900	ELECTROCARDIOLOGY	386,131	26,294	22,497	70,369	10,753	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	1,274,152	5,340	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	830,899	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	99,962	16,097	2,945	16,294	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	371,797	0	33,462	69,100	131,802	90.00
90.01	09001	OB CLINIC	38,605	57,826	2,568	5,092	0	90.01
90.02	09002	SPECIALTY CLINIC	5,652	10,451	0	192	0	90.02
90.03	09003	SURGICAL CLINIC	211,993	0	7,100	506	0	90.03
91.00	09100	EMERGENCY	1,503,591	152,195	19,605	157,936	74,357	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	621,273	25,633	268	156,926	24,014	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,148,982	2,555,092	1,038,763	3,682,070	938,029	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,910	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	200,929	0	4,718	47	0	192.01
192.02	19201	CARDIOLOGY CLINIC	3,822	0	0	0	0	192.02
192.03	19202	LEASED SPACE	72,501	65,353	8,493	2,128	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	8,544	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	12,359	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B Part I Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	407,123	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	31,426,234	3,062,381	1,051,974	3,684,245	938,029	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B Part I Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
		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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES	219,336					5.02
5.03	00570	ADMITTING	137	294,096				5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	463	0	541,727			5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	1,064	0	0	2,487,919	2,487,919	5.05
7.00	00700	OPERATION OF PLANT	3,283	0	0	1,369,685	119,437	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	289	0	0	175,126	15,271	8.00
9.00	00900	HOUSEKEEPING	4,195	0	0	586,780	51,167	9.00
10.00	01000	DIETARY	1,768	0	0	903,309	78,769	10.00
11.00	01100	CAFETERIA	0	0	0	51,277	4,471	11.00
13.00	01300	NURSING ADMINISTRATION	7	0	0	410,788	35,821	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,284	0	0	31,268	2,727	14.00
15.00	01500	PHARMACY	187	0	0	478,474	41,723	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	262	0	0	641,722	55,958	16.00
17.00	01700	SOCIAL SERVICE	3	0	0	182,267	15,894	17.00
18.00	01080	INSERVICE EDUCATION	211	0	0	183,290	15,983	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,925	16,073	28,516	3,282,269	286,214	30.00
43.00	04300	NURSERY	96	1,648	2,923	95,865	8,359	43.00
44.00	04400	SKILLED NURSING FACILITY	2,559	0	16,419	1,598,048	139,350	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	61,186	66,379	104,680	3,779,101	329,536	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,055	3,646	117,969	10,287	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,531	57,028	101,177	2,940,077	256,375	54.00
60.00	06000	LABORATORY	25,390	32,762	58,126	1,877,097	163,683	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,270	2,253	142,184	12,398	62.00
64.00	06400	INTRAVENOUS THERAPY	215	14,263	25,305	50,521	4,405	64.00
66.00	06600	PHYSICAL THERAPY	1,790	17,834	31,640	1,730,609	150,909	66.00
67.00	06700	OCCUPATIONAL THERAPY	194	6,061	10,753	616,820	53,787	67.00
68.00	06800	SPEECH PATHOLOGY	0	783	1,388	126,027	10,990	68.00
69.00	06900	ELECTROCARDIOLOGY	625	11,214	19,392	547,275	47,722	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,744	3,094	4,838	422	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,276	10,970	19,462	1,387,200	120,964	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	15,427	27,370	873,696	76,186	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	165	2,748	4,876	143,087	12,477	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	2,336	0	4,134	612,631	53,421	90.00
90.01	09001	OB CLINIC	759	0	1,238	106,088	9,251	90.01
90.02	09002	SPECIALTY CLINIC	97	0	43	16,435	1,433	90.02
90.03	09003	SURGICAL CLINIC	497	0	4,352	224,448	19,572	90.03
91.00	09100	EMERGENCY	5,882	28,487	31,063	1,973,116	172,056	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	2,199	0	6,855	837,168	73,001	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	217,875	286,746	508,705	30,584,474	2,450,019	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	13,910	1,213	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	1,441	0	0	207,135	18,062	192.01
192.02	19201	CARDIOLOGY CLINIC	8	0	0	3,830	334	192.02
192.03	19202	LEASED SPACE	12	0	0	148,487	12,948	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	8,544	745	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	19,982	19,982	1,742	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	12,359	1,078	194.02
194.03	07952	ANESTHESIA BILLNG	0	7,350	13,040	20,390	1,778	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	407,123	0	194.06
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	219,336	294,096	541,727	31,426,234	2,487,919	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B Part I | Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	1,489,122					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	13,622	204,019				8.00
9.00	00900	HOUSEKEEPING	23,740	18,673	680,360			9.00
10.00	01000	DIETARY	54,007	1,302	37,971	1,075,358		10.00
11.00	01100	CAFETERIA	35,175	0	25,454	729,815	846,192	11.00
13.00	01300	NURSING ADMINISTRATION	14,938	0	0	0	15,535	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,885	0	0	0	0	14.00
15.00	01500	PHARMACY	21,873	0	3,951	0	14,503	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	24,700	0	3,706	0	53,110	16.00
17.00	01700	SOCIAL SERVICE	5,993	0	2,447	0	12,129	17.00
18.00	01080	INSERVICE EDUCATION	16,467	0	0	0	7,794	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	202,601	43,948	167,687	89,676	167,278	30.00
43.00	04300	NURSERY	4,090	0	1,049	0	4,439	43.00
44.00	04400	SKILLED NURSING FACILITY	260,874	61,826	145,933	255,867	121,703	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	213,822	27,215	119,962	0	122,632	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,832	0	0	0	6,297	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	132,536	16,507	27,167	0	59,922	54.00
60.00	06000	LABORATORY	41,470	0	8,182	0	64,619	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,369	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	3,023	0	0	0	103	64.00
66.00	06600	PHYSICAL THERAPY	137,248	13,368	18,881	0	96,206	66.00
67.00	06700	OCCUPATIONAL THERAPY	52,246	0	1,818	0	29,626	67.00
68.00	06800	SPEECH PATHOLOGY	9,069	0	0	0	5,832	68.00
69.00	06900	ELECTROCARDIOLOGY	18,388	0	7,412	0	19,458	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	3,734	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	11,257	1,342	10,175	0	5,006	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	40,438	0	4,021	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	106,431	19,838	27,692	0	40,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	17,925	0	4,965	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,470,753	204,019	618,473	1,075,358	846,192	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,727	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	61,887	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	8,642	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	1,489,122	204,019	680,360	1,075,358	846,192	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B Part I Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	477,082					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	35,880				14.00
15.00	01500	PHARMACY	14,221	0	574,745			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	779,196		16.00
17.00	01700	SOCIAL SERVICE	11,893	0	0	0	230,623	17.00
18.00	01080	INSERVICE EDUCATION	7,642	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	164,021	0	0	42,326	107,451	30.00
43.00	04300	NURSERY	4,352	0	0	4,339	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	9,672	100,691	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	120,245	0	0	155,371	3,301	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,174	0	0	5,412	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	150,174	0	54.00
60.00	06000	LABORATORY	63,361	0	0	86,274	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	3,344	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	37,559	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	46,963	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	15,961	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,061	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	28,783	472	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	35,880	0	4,593	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	28,887	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	574,745	40,625	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	7,237	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	6,136	5,738	90.00
90.01	09001	OB CLINIC	0	0	0	1,837	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	64	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	6,460	0	90.03
91.00	09100	EMERGENCY	39,221	0	0	46,105	8,804	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	45,952	0	0	0	4,166	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	477,082	35,880	574,745	730,183	230,623	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
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	29,658	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	19,355	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	477,082	35,880	574,745	779,196	230,623	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B Part I | Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
18.00	01080	INSERVICE EDUCATION	231,176					18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,480	4,565,951	0	4,565,951		30.00
43.00	04300	NURSERY	1,279	123,772	0	123,772		43.00
44.00	04400	SKILLED NURSING FACILITY	2,852	2,696,816	0	2,696,816		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	51,514	4,922,699	0	4,922,699		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,596	149,567	0	149,567		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,279	3,627,037	0	3,627,037		54.00
60.00	06000	LABORATORY	25,438	2,330,124	0	2,330,124		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	986	160,281	0	160,281		62.00
64.00	06400	INTRAVENOUS THERAPY	11,074	106,685	0	106,685		64.00
66.00	06600	PHYSICAL THERAPY	13,847	2,208,031	0	2,208,031		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,706	774,964	0	774,964		67.00
68.00	06800	SPEECH PATHOLOGY	608	154,587	0	154,587		68.00
69.00	06900	ELECTROCARDIOLOGY	8,707	678,217	0	678,217		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,354	47,087	0	47,087		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,518	1,549,303	0	1,549,303		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,978	1,577,230	0	1,577,230		73.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	2,134	192,715	0	192,715		76.01
76.02	03950	IV THERAPY	0	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	677,926	0	677,926		90.00
90.01	09001	OB CLINIC	0	161,635	0	161,635		90.01
90.02	09002	SPECIALTY CLINIC	0	17,932	0	17,932		90.02
90.03	09003	SURGICAL CLINIC	0	250,480	0	250,480		90.03
91.00	09100	EMERGENCY	22,119	2,455,382	0	2,455,382		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	983,177	0	983,177		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	225,469	30,411,598	0	30,411,598		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24,850	0	24,850		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19203	MUSCATINE CLINIC	0	225,197	0	225,197		192.01
192.02	19201	CARDIOLOGY CLINIC	0	66,051	0	66,051		192.02
192.03	19202	LEASED SPACE	0	161,435	0	161,435		192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	9,289	0	9,289		194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	51,382	0	51,382		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	22,079	0	22,079		194.02
194.03	07952	ANESTHESIA BILLNG	5,707	47,230	0	47,230		194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07954	COLONA CLINIC	0	0	0	0		194.05

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B Part I Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	407,123	0	407,123		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	231,176	31,426,234	0	31,426,234		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B Part II | Date/Time Prepared: 10/17/2015 11:48 am

		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	14,596	0	14,596	14,596	4.00
5.01	00550	DATA PROCESSING	0	60,725	91,231	151,956	444	5.01
5.02	00560	PURCHASING RECEIVING AND STORES	0	65,506	0	65,506	142	5.02
5.03	00570	ADMITTING	0	26,167	0	26,167	193	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	24,387	226	24,613	340	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	0	69,346	12,831	82,177	441	5.05
7.00	00700	OPERATION OF PLANT	0	180,752	24,802	205,554	237	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,479	1,473	20,952	39	8.00
9.00	00900	HOUSEKEEPING	0	33,948	0	33,948	423	9.00
10.00	01000	DIETARY	0	77,229	6,285	83,514	541	10.00
11.00	01100	CAFETERIA	0	50,299	0	50,299	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	21,361	687	22,048	328	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,696	0	2,696	0	14.00
15.00	01500	PHARMACY	0	31,278	3,803	35,081	253	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,321	3,327	38,648	426	16.00
17.00	01700	SOCIAL SERVICE	0	8,570	39	8,609	154	17.00
18.00	01080	INSERVICE EDUCATION	0	23,548	4,777	28,325	126	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	289,717	90,540	380,257	2,311	30.00
43.00	04300	NURSERY	0	5,849	6,414	12,263	73	43.00
44.00	04400	SKILLED NURSING FACILITY	0	373,049	37,522	410,571	984	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	305,763	220,083	525,846	1,605	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,619	0	2,619	103	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	189,525	363,827	553,352	845	54.00
60.00	06000	LABORATORY	0	59,301	54,139	113,440	748	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	1,958	0	1,958	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	4,323	0	4,323	3	64.00
66.00	06600	PHYSICAL THERAPY	0	196,264	28,312	224,576	1,373	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	74,711	0	74,711	471	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,969	0	12,969	96	68.00
69.00	06900	ELECTROCARDIOLOGY	0	26,294	22,497	48,791	279	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	5,340	0	5,340	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	16,097	2,945	19,042	65	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	33,462	33,462	274	90.00
90.01	09001	OB CLINIC	0	57,826	2,568	60,394	20	90.01
90.02	09002	SPECIALTY CLINIC	0	10,451	0	10,451	1	90.02
90.03	09003	SURGICAL CLINIC	0	0	7,100	7,100	2	90.03
91.00	09100	EMERGENCY	0	152,195	19,605	171,800	626	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	25,633	268	25,901	622	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,555,092	1,038,763	3,593,855	14,588	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,910	0	13,910	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	4,718	4,718	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	65,353	8,493	73,846	8	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	8,544	0	8,544	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	12,359	0	12,359	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	407,123	0	407,123	0	194.06

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B Part II Date/Time Prepared: 10/17/2015 11:48 am

	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	
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	3,062,381	1,051,974	4,114,355	14,596	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B Part II Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	DATA PROCESSING	PURCHASING RECEIVING AND STORES	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
		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
5.01	00550	DATA PROCESSING	152,400					5.01
5.02	00560	PURCHASING RECEIVING AND STORES	990	66,638				5.02
5.03	00570	ADMITTING	3,716	42	30,118			5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	141	0	25,094		5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	19,979	323	0	0	102,920	5.05
7.00	00700	OPERATION OF PLANT	0	998	0	0	4,940	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	88	0	0	632	8.00
9.00	00900	HOUSEKEEPING	106	1,275	0	0	2,117	9.00
10.00	01000	DIETARY	847	537	0	0	3,258	10.00
11.00	01100	CAFETERIA	159	0	0	0	185	11.00
13.00	01300	NURSING ADMINISTRATION	1,853	2	0	0	1,482	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	694	0	0	113	14.00
15.00	01500	PHARMACY	2,594	57	0	0	1,726	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	13,473	80	0	0	2,315	16.00
17.00	01700	SOCIAL SERVICE	1,244	1	0	0	657	17.00
18.00	01080	INSERVICE EDUCATION	0	64	0	0	661	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,904	3,015	1,648	1,321	11,839	30.00
43.00	04300	NURSERY	0	29	169	135	346	43.00
44.00	04400	SKILLED NURSING FACILITY	7,210	777	0	761	5,764	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,526	18,590	6,774	4,844	13,636	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	211	169	426	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,924	3,807	5,846	4,688	10,605	54.00
60.00	06000	LABORATORY	5,728	7,714	3,359	2,693	6,771	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	130	104	513	62.00
64.00	06400	INTRAVENOUS THERAPY	0	65	1,462	1,173	182	64.00
66.00	06600	PHYSICAL THERAPY	4,156	544	1,828	1,466	6,242	66.00
67.00	06700	OCCUPATIONAL THERAPY	582	59	621	498	2,225	67.00
68.00	06800	SPEECH PATHOLOGY	265	0	80	64	455	68.00
69.00	06900	ELECTROCARDIOLOGY	1,747	190	1,150	899	1,974	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	179	143	17	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,476	1,125	902	5,004	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,581	1,268	3,151	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	50	282	226	516	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	21,414	710	0	192	2,210	90.00
90.01	09001	OB CLINIC	0	231	0	57	383	90.01
90.02	09002	SPECIALTY CLINIC	0	29	0	2	59	90.02
90.03	09003	SURGICAL CLINIC	0	151	0	202	810	90.03
91.00	09100	EMERGENCY	12,081	1,787	2,920	1,439	7,117	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	3,902	668	0	318	3,020	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	152,400	66,194	29,365	23,564	101,351	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	50	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	438	0	0	747	192.01
192.02	19201	CARDIOLOGY CLINIC	0	2	0	0	14	192.02
192.03	19202	LEASED SPACE	0	4	0	0	536	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	31	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	926	72	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	45	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	753	604	74	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	152,400	66,638	30,118	25,094	102,920	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B Part II | Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	211,729					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,937	23,648				8.00
9.00	00900	HOUSEKEEPING	3,375	2,164	43,408			9.00
10.00	01000	DIETARY	7,679	151	2,423	98,950		10.00
11.00	01100	CAFETERIA	5,001	0	1,624	67,154	124,422	11.00
13.00	01300	NURSING ADMINISTRATION	2,124	0	0	0	2,284	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	268	0	0	0	0	14.00
15.00	01500	PHARMACY	3,110	0	252	0	2,133	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,512	0	236	0	7,809	16.00
17.00	01700	SOCIAL SERVICE	852	0	156	0	1,783	17.00
18.00	01080	INSERVICE EDUCATION	2,341	0	0	0	1,146	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,807	5,094	10,698	8,252	24,596	30.00
43.00	04300	NURSERY	582	0	67	0	653	43.00
44.00	04400	SKILLED NURSING FACILITY	37,091	7,167	9,311	23,544	17,895	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	30,402	3,155	7,654	0	18,032	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	260	0	0	0	926	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,844	1,913	1,733	0	8,811	54.00
60.00	06000	LABORATORY	5,896	0	522	0	9,501	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	195	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	430	0	0	0	15	64.00
66.00	06600	PHYSICAL THERAPY	19,514	1,549	1,205	0	14,146	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,429	0	116	0	4,356	67.00
68.00	06800	SPEECH PATHOLOGY	1,290	0	0	0	858	68.00
69.00	06900	ELECTROCARDIOLOGY	2,614	0	473	0	2,861	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	531	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,601	156	649	0	736	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	5,750	0	257	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	15,133	2,299	1,767	0	5,881	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	2,549	0	317	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	209,117	23,648	39,460	98,950	124,422	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,383	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	3,948	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	1,229	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	211,729	23,648	43,408	98,950	124,422	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B Part II | Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			13.00	14.00	15.00	16.00	17.00	
		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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	30,121					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,771				14.00
15.00	01500	PHARMACY	898	0	46,104			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	66,499		16.00
17.00	01700	SOCIAL SERVICE	751	0	0	0	14,207	17.00
18.00	01080	INSERVICE EDUCATION	482	0	0	0	0	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,356	0	0	3,613	6,620	30.00
43.00	04300	NURSERY	275	0	0	370	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	826	6,203	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,592	0	0	13,244	203	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	390	0	0	462	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	12,821	0	54.00
60.00	06000	LABORATORY	4,000	0	0	7,365	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	285	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	3,207	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,009	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	1,363	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	176	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	2,457	29	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,771	0	392	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,466	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	46,104	3,468	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	618	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	524	353	90.00
90.01	09001	OB CLINIC	0	0	0	157	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	5	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	551	0	90.03
91.00	09100	EMERGENCY	2,476	0	0	3,936	542	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	2,901	0	0	0	257	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	30,121	3,771	46,104	62,315	14,207	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
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	2,532	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	1,652	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	30,121	3,771	46,104	66,499	14,207	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B Part II | Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
18.00	01080	INSERVICE EDUCATION	33,145					18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,790	530,121	0	530,121		30.00
43.00	04300	NURSERY	184	15,146	0	15,146		43.00
44.00	04400	SKILLED NURSING FACILITY	409	528,513	0	528,513		44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,371	672,474	0	672,474		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	229	5,795	0	5,795		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,353	636,542	0	636,542		54.00
60.00	06000	LABORATORY	3,649	171,386	0	171,386		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	141	3,326	0	3,326		62.00
64.00	06400	INTRAVENOUS THERAPY	1,589	12,449	0	12,449		64.00
66.00	06600	PHYSICAL THERAPY	1,987	282,595	0	282,595		66.00
67.00	06700	OCCUPATIONAL THERAPY	675	93,106	0	93,106		67.00
68.00	06800	SPEECH PATHOLOGY	87	16,340	0	16,340		68.00
69.00	06900	ELECTROCARDIOLOGY	1,249	64,713	0	64,713		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	194	4,696	0	4,696		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,222	40,066	0	40,066		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,718	57,290	0	57,290		73.00
76.00	03020	ACUPUNCTURE	0	0	0	0		76.00
76.01	03610	SLEEP LAB	306	24,247	0	24,247		76.01
76.02	03950	IV THERAPY	0	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0		88.00
90.00	09000	CLINIC	0	59,139	0	59,139		90.00
90.01	09001	OB CLINIC	0	67,249	0	67,249		90.01
90.02	09002	SPECIALTY CLINIC	0	10,547	0	10,547		90.02
90.03	09003	SURGICAL CLINIC	0	8,816	0	8,816		90.03
91.00	09100	EMERGENCY	3,173	232,977	0	232,977		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	40,455	0	40,455		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	32,326	3,577,988	0	3,577,988		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,343	0	15,343		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192.01	19203	MUSCATINE CLINIC	0	5,903	0	5,903		192.01
192.02	19201	CARDIOLOGY CLINIC	0	3,964	0	3,964		192.02
192.03	19202	LEASED SPACE	0	74,394	0	74,394		192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	8,575	0	8,575		194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	3,530	0	3,530		194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	13,633	0	13,633		194.02
194.03	07952	ANESTHESIA BILLNG	819	3,902	0	3,902		194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0		194.04
194.05	07954	COLONA CLINIC	0	0	0	0		194.05

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B Part II Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			18.00	24.00	25.00	26.00		
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	407,123	0	407,123		194.06
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	33,145	4,114,355	0	4,114,355		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	120,427					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		968,987				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	574	0	11,794,664			4.00
5.01	00550	DATA PROCESSING	2,388	84,034	358,413	143,940		5.01
5.02	00560	PURCHASING RECEIVING AND STORES	2,576	0	114,436	935	3,616,559	5.02
5.03	00570	ADMITTING	1,029	0	155,792	3,510	2,264	5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	959	208	274,979	0	7,639	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	2,727	11,819	356,020	18,870	17,545	5.05
7.00	00700	OPERATION OF PLANT	7,108	22,845	191,427	0	54,140	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	766	1,357	31,132	0	4,771	8.00
9.00	00900	HOUSEKEEPING	1,335	0	341,522	100	69,173	9.00
10.00	01000	DIETARY	3,037	5,789	437,050	800	29,146	10.00
11.00	01100	CAFETERIA	1,978	0	0	150	0	11.00
13.00	01300	NURSING ADMINISTRATION	840	633	264,915	1,750	122	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	106	0	0	0	37,656	14.00
15.00	01500	PHARMACY	1,230	3,503	203,962	2,450	3,076	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,389	3,065	343,864	12,725	4,327	16.00
17.00	01700	SOCIAL SERVICE	337	36	124,637	1,175	53	17.00
18.00	01080	INSERVICE EDUCATION	926	4,400	101,551	0	3,478	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,393	83,398	1,873,028	28,245	163,650	30.00
43.00	04300	NURSERY	230	5,908	58,942	0	1,582	43.00
44.00	04400	SKILLED NURSING FACILITY	14,670	34,562	794,775	6,810	42,188	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,024	202,721	1,296,615	12,775	1,008,877	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	103	0	83,551	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,453	335,126	682,519	6,540	206,615	54.00
60.00	06000	LABORATORY	2,332	49,868	603,836	5,410	418,648	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	77	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	170	0	2,187	0	3,545	64.00
66.00	06600	PHYSICAL THERAPY	7,718	26,079	1,109,142	3,925	29,522	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,938	0	380,729	550	3,202	67.00
68.00	06800	SPEECH PATHOLOGY	510	0	77,487	250	5	68.00
69.00	06900	ELECTROCARDIOLOGY	1,034	20,722	225,279	1,650	10,300	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	210	0	0	0	1,274,152	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	633	2,713	52,162	0	2,727	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	30,822	221,217	20,225	38,523	90.00
90.01	09001	OB CLINIC	2,274	2,365	16,303	0	12,515	90.01
90.02	09002	SPECIALTY CLINIC	411	0	614	0	1,598	90.02
90.03	09003	SURGICAL CLINIC	0	6,540	1,620	0	8,200	90.03
91.00	09100	EMERGENCY	5,985	18,058	505,615	11,410	96,983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,008	247	502,381	3,685	36,257	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100,478	956,818	11,787,702	143,940	3,592,479	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	547	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	4,346	149	0	23,759	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	130	192.02
192.03	19202	LEASED SPACE	2,570	7,823	6,813	0	191	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	336	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	486	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	
			1.00	2.00	4.00	5.01	5.02	
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	16,010	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,062,381	1,051,974	3,684,245	938,029	219,336	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	25.429356	1.085643	0.312365	6.516806	0.060648	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			14,596	152,400	66,638	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001238	1.058774	0.018426	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
		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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING	74,616,902					5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	77,477,502				5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	-2,487,919	28,531,192		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	1,369,685	83,739	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	175,126	766	8.00
9.00	00900	HOUSEKEEPING	0	0	0	586,780	1,335	9.00
10.00	01000	DIETARY	0	0	0	903,309	3,037	10.00
11.00	01100	CAFETERIA	0	0	0	51,277	1,978	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	410,788	840	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	31,268	106	14.00
15.00	01500	PHARMACY	0	0	0	478,474	1,230	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	641,722	1,389	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	182,267	337	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	183,290	926	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,078,406	4,078,406	0	3,282,269	11,393	30.00
43.00	04300	NURSERY	418,063	418,063	0	95,865	230	43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,348,226	0	1,598,048	14,670	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	16,835,503	14,970,529	0	3,779,101	12,024	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	521,490	521,490	0	117,969	103	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,470,408	14,470,408	0	2,940,077	7,453	54.00
60.00	06000	LABORATORY	8,313,204	8,313,204	0	1,877,097	2,332	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	322,220	322,220	0	142,184	77	62.00
64.00	06400	INTRAVENOUS THERAPY	3,619,087	3,619,087	0	50,521	170	64.00
66.00	06600	PHYSICAL THERAPY	4,525,232	4,525,232	0	1,730,609	7,718	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,537,950	1,537,950	0	616,820	2,938	67.00
68.00	06800	SPEECH PATHOLOGY	198,581	198,581	0	126,027	510	68.00
69.00	06900	ELECTROCARDIOLOGY	2,845,512	2,773,421	0	547,275	1,034	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	442,539	442,539	0	4,838	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,783,514	2,783,514	0	1,387,200	210	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,914,525	3,914,525	0	873,696	0	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	697,382	697,382	0	143,087	633	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	591,260	0	612,631	0	90.00
90.01	09001	OB CLINIC	0	177,041	0	106,088	2,274	90.01
90.02	09002	SPECIALTY CLINIC	0	6,199	0	16,435	0	90.02
90.03	09003	SURGICAL CLINIC	0	622,439	0	224,448	0	90.03
91.00	09100	EMERGENCY	7,228,312	4,442,581	0	1,973,116	5,985	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	980,409	0	837,168	1,008	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	72,751,928	72,754,706	-2,487,919	28,096,555	82,706	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	13,910	547	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19203	MUSCATINE CLINIC	0	0	0	207,135	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	3,830	0	192.02
192.03	19202	LEASED SPACE	0	0	0	148,487	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	8,544	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	2,857,822	0	19,982	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	12,359	486	194.02
194.03	07952	ANESTHESIA BILLNG	1,864,974	1,864,974	0	20,390	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	-407,123	0	0	194.06
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	ADMITTING (GROSS CHARGES)	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	294,096	541,727		2,487,919	1,489,122	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003941	0.006992		0.087200	17.782897	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	30,118	25,094		102,920	211,729	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000404	0.000324		0.003607	2.528440	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	
			8.00	9.00	10.00	11.00	13.00	
		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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	276,836					8.00
9.00	00900	HOUSEKEEPING	25,338	583,764				9.00
10.00	01000	DIETARY	1,767	32,580	162,102			10.00
11.00	01100	CAFETERIA	0	21,840	110,014	16,395		11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	301	9,427	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	3,390	0	281	281	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,180	0	1,029	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,100	0	235	235	17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	151	151	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	59,634	143,880	13,518	3,241	3,241	30.00
43.00	04300	NURSERY	0	900	0	86	86	43.00
44.00	04400	SKILLED NURSING FACILITY	83,892	125,214	38,570	2,358	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,929	102,930	0	2,376	2,376	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	122	122	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,398	23,310	0	1,161	0	54.00
60.00	06000	LABORATORY	0	7,020	0	1,252	1,252	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	2	0	64.00
66.00	06600	PHYSICAL THERAPY	18,139	16,200	0	1,864	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,560	0	574	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	113	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,360	0	377	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	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	1,821	8,730	0	97	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	3,450	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	26,918	23,760	0	775	775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	4,260	0	0	908	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	276,836	530,664	162,102	16,395	9,427	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
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	53,100	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	0	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	0	0	0	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	
			8.00	9.00	10.00	11.00	13.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	204,019	680,360	1,075,358	846,192	477,082	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.736967	1.165471	6.633835	51.612809	50.608041	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	23,648	43,408	98,950	124,422	30,121	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.085422	0.074359	0.610418	7.589021	3.195184	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHAR GES)	
			14.00	15.00	16.00	17.00	18.00	
		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
5.01	00550	DATA PROCESSING						5.01
5.02	00560	PURCHASING RECEIVING AND STORES						5.02
5.03	00570	ADMITTING						5.03
5.04	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	100					14.00
15.00	01500	PHARMACY	0	100				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	75,080,796			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	73,350		17.00
18.00	01080	INSERVICE EDUCATION	0	0	0	0	75,548,831	18.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	4,078,406	34,175	4,078,406	30.00
43.00	04300	NURSERY	0	0	418,063	0	418,063	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	931,929	32,025	931,929	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	14,970,529	1,050	16,835,503	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	521,490	0	521,490	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	14,470,408	0	14,470,408	54.00
60.00	06000	LABORATORY	0	0	8,313,204	0	8,313,204	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	322,220	0	322,220	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	3,619,087	0	3,619,087	64.00
66.00	06600	PHYSICAL THERAPY	0	0	4,525,232	0	4,525,232	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	1,537,950	0	1,537,950	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	198,581	0	198,581	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	2,773,421	150	2,845,512	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	100	0	442,539	0	442,539	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	2,783,514	0	2,783,514	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	100	3,914,525	0	3,914,525	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	697,382	0	697,382	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	591,260	1,825	0	90.00
90.01	09001	OB CLINIC	0	0	177,041	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	6,199	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	622,439	0	0	90.03
91.00	09100	EMERGENCY	0	0	4,442,581	2,800	7,228,312	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,325	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100	70,358,000	73,350	73,683,857	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
192.01	19203	MUSCATINE CLINIC	0	0	0	0	0	192.01
192.02	19201	CARDIOLOGY CLINIC	0	0	0	0	0	192.02
192.03	19202	LEASED SPACE	0	0	0	0	0	192.03
194.00	07955	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194.01	07950	PHYSICIAN BILLING COSTS	0	0	2,857,822	0	0	194.01
194.02	07951	KELLY MEDICAL RENTAL AREA	0	0	0	0	0	194.02
194.03	07952	ANESTHESIA BILLNG	0	0	1,864,974	0	1,864,974	194.03
194.04	07953	SPECIALTY CLINIC	0	0	0	0	0	194.04
194.05	07954	COLONA CLINIC	0	0	0	0	0	194.05

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet B-1 | Date/Time Prepared: 10/17/2015 11:48 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHAR GES)	
			14.00	15.00	16.00	17.00	18.00	
194.06	07956	TRINITY/DIALYSIS LEASED SPACE	0	0	0	0	0	194.06
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)	35,880	574,745	779,196	230,623	231,176	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	358.800000	5,747.450000	0.010378	3.144145	0.003060	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,771	46,104	66,499	14,207	33,145	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	37.710000	461.040000	0.000886	0.193688	0.000439	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet C Part I Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,565,951		4,565,951	0	4,565,951	30.00
43.00	04300	NURSERY	123,772		123,772	0	123,772	43.00
44.00	04400	SKILLED NURSING FACILITY	2,696,816		2,696,816	0	2,696,816	44.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,922,699		4,922,699	0	4,922,699	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	149,567		149,567	0	149,567	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,627,037		3,627,037	0	3,627,037	54.00
60.00	06000	LABORATORY	2,330,124		2,330,124	0	2,330,124	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	160,281		160,281	0	160,281	62.00
64.00	06400	INTRAVENOUS THERAPY	106,685		106,685	0	106,685	64.00
66.00	06600	PHYSICAL THERAPY	2,208,031	0	2,208,031	0	2,208,031	66.00
67.00	06700	OCCUPATIONAL THERAPY	774,964	0	774,964	0	774,964	67.00
68.00	06800	SPEECH PATHOLOGY	154,587	0	154,587	0	154,587	68.00
69.00	06900	ELECTROCARDIOLOGY	678,217		678,217	0	678,217	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,087		47,087	0	47,087	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,549,303		1,549,303	0	1,549,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,577,230		1,577,230	0	1,577,230	73.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	192,715		192,715	0	192,715	76.01
76.02	03950	IV THERAPY	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	677,926		677,926	0	677,926	90.00
90.01	09001	OB CLINIC	161,635		161,635	0	161,635	90.01
90.02	09002	SPECIALTY CLINIC	17,932		17,932	0	17,932	90.02
90.03	09003	SURGICAL CLINIC	250,480		250,480	0	250,480	90.03
91.00	09100	EMERGENCY	2,455,382		2,455,382	0	2,455,382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	549,262		549,262		549,262	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	983,177		983,177		983,177	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,960,860	0	30,960,860	0	30,960,860	200.00
201.00		Less Observation Beds	549,262		549,262		549,262	201.00
202.00		Total (see instructions)	30,411,598	0	30,411,598	0	30,411,598	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet C Part I Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,534,629		3,534,629			30.00
43.00	04300	NURSERY	418,063		418,063			43.00
44.00	04400	SKILLED NURSING FACILITY	2,348,226		2,348,226			44.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,898,948	10,071,347	14,970,295	0.328831	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	428,060	93,430	521,490	0.286807	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	706,997	13,763,411	14,470,408	0.250652	0.000000	54.00
60.00	06000	LABORATORY	1,110,886	7,202,318	8,313,204	0.280292	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	195,354	126,866	322,220	0.497427	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	2,686,753	932,334	3,619,087	0.029478	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	669,963	3,855,269	4,525,232	0.487938	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	415,635	1,122,315	1,537,950	0.503894	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	60,674	137,907	198,581	0.778458	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	156,744	2,616,677	2,773,421	0.244542	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	366,067	76,472	442,539	0.106402	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,427,804	355,710	2,783,514	0.556600	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,766,740	2,147,785	3,914,525	0.402917	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	697,382	697,382	0.276341	0.000000	76.01
76.02	03950	IV THERAPY	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
90.00	09000	CLINIC	0	591,260	591,260	1.146578	0.000000	90.00
90.01	09001	OB CLINIC	72,660	104,382	177,042	0.912975	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0	6,199	6,199	2.892725	0.000000	90.02
90.03	09003	SURGICAL CLINIC	0	622,439	622,439	0.402417	0.000000	90.03
91.00	09100	EMERGENCY	24,968	4,417,613	4,442,581	0.552693	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	31,018	512,760	543,778	1.010085	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	980,409	980,409			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,320,189	50,434,285	72,754,474			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,320,189	50,434,285	72,754,474			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet C Part I Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
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	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.02	03950	IV THERAPY	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OB CLINIC	0.000000		90.01
90.02	09002	SPECIALTY CLINIC	0.000000		90.02
90.03	09003	SURGICAL CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet C Part I Date/Time Prepared: 10/17/2015 11:48 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,565,951		4,565,951	0	4,565,951	30.00
43.00	04300	NURSERY	123,772		123,772	0	123,772	43.00
44.00	04400	SKILLED NURSING FACILITY	2,696,816		2,696,816	0	2,696,816	44.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,922,699		4,922,699	0	4,922,699	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	149,567		149,567	0	149,567	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,627,037		3,627,037	0	3,627,037	54.00
60.00	06000	LABORATORY	2,330,124		2,330,124	0	2,330,124	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	160,281		160,281	0	160,281	62.00
64.00	06400	INTRAVENOUS THERAPY	106,685		106,685	0	106,685	64.00
66.00	06600	PHYSICAL THERAPY	2,208,031	0	2,208,031	0	2,208,031	66.00
67.00	06700	OCCUPATIONAL THERAPY	774,964	0	774,964	0	774,964	67.00
68.00	06800	SPEECH PATHOLOGY	154,587	0	154,587	0	154,587	68.00
69.00	06900	ELECTROCARDIOLOGY	678,217		678,217	0	678,217	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,087		47,087	0	47,087	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,549,303		1,549,303	0	1,549,303	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,577,230		1,577,230	0	1,577,230	73.00
76.00	03020	ACUPUNCTURE	0		0	0	0	76.00
76.01	03610	SLEEP LAB	192,715		192,715	0	192,715	76.01
76.02	03950	IV THERAPY	0		0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
90.00	09000	CLINIC	677,926		677,926	0	677,926	90.00
90.01	09001	OB CLINIC	161,635		161,635	0	161,635	90.01
90.02	09002	SPECIALTY CLINIC	17,932		17,932	0	17,932	90.02
90.03	09003	SURGICAL CLINIC	250,480		250,480	0	250,480	90.03
91.00	09100	EMERGENCY	2,455,382		2,455,382	0	2,455,382	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	549,262		549,262		549,262	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	983,177		983,177		983,177	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	30,960,860	0	30,960,860	0	30,960,860	200.00
201.00		Less Observation Beds	549,262		549,262		549,262	201.00
202.00		Total (see instructions)	30,411,598	0	30,411,598	0	30,411,598	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet C Part I Date/Time Prepared: 10/17/2015 11:48 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,534,629		3,534,629			30.00
43.00	04300	NURSERY	418,063		418,063			43.00
44.00	04400	SKILLED NURSING FACILITY	2,348,226		2,348,226			44.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,898,948	10,071,347	14,970,295	0.328831	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	428,060	93,430	521,490	0.286807	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	706,997	13,763,411	14,470,408	0.250652	0.000000	54.00
60.00	06000	LABORATORY	1,110,886	7,202,318	8,313,204	0.280292	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	195,354	126,866	322,220	0.497427	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	2,686,753	932,334	3,619,087	0.029478	0.000000	64.00
66.00	06600	PHYSICAL THERAPY	669,963	3,855,269	4,525,232	0.487938	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	415,635	1,122,315	1,537,950	0.503894	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	60,674	137,907	198,581	0.778458	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	156,744	2,616,677	2,773,421	0.244542	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	366,067	76,472	442,539	0.106402	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,427,804	355,710	2,783,514	0.556600	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,766,740	2,147,785	3,914,525	0.402917	0.000000	73.00
76.00	03020	ACUPUNCTURE	0	0	0	0.000000	0.000000	76.00
76.01	03610	SLEEP LAB	0	697,382	697,382	0.276341	0.000000	76.01
76.02	03950	IV THERAPY	0	0	0	0.000000	0.000000	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
90.00	09000	CLINIC	0	591,260	591,260	1.146578	0.000000	90.00
90.01	09001	OB CLINIC	72,660	104,382	177,042	0.912975	0.000000	90.01
90.02	09002	SPECIALTY CLINIC	0	6,199	6,199	2.892725	0.000000	90.02
90.03	09003	SURGICAL CLINIC	0	622,439	622,439	0.402417	0.000000	90.03
91.00	09100	EMERGENCY	24,968	4,417,613	4,442,581	0.552693	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	31,018	512,760	543,778	1.010085	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	980,409	980,409			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	22,320,189	50,434,285	72,754,474			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	22,320,189	50,434,285	72,754,474			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet C Part I Date/Time Prepared: 10/17/2015 11:48 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000		62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
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	03020	ACUPUNCTURE	0.000000		76.00
76.01	03610	SLEEP LAB	0.000000		76.01
76.02	03950	IV THERAPY	0.000000		76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OB CLINIC	0.000000		90.01
90.02	09002	SPECIALTY CLINIC	0.000000		90.02
90.03	09003	SURGICAL CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D Part II Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	672,474	14,970,295	0.044921	2,377,848	106,815	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,795	521,490	0.011112	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	636,542	14,470,408	0.043989	403,618	17,755	54.00
60.00	06000	LABORATORY	171,386	8,313,204	0.020616	481,814	9,933	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	3,326	322,220	0.010322	135,994	1,404	62.00
64.00	06400	INTRAVENOUS THERAPY	12,449	3,619,087	0.003440	1,254,990	4,317	64.00
66.00	06600	PHYSICAL THERAPY	282,595	4,525,232	0.062449	180,139	11,250	66.00
67.00	06700	OCCUPATIONAL THERAPY	93,106	1,537,950	0.060539	106,244	6,432	67.00
68.00	06800	SPEECH PATHOLOGY	16,340	198,581	0.082284	16,861	1,387	68.00
69.00	06900	ELECTROCARDIOLOGY	64,713	2,773,421	0.023333	113,002	2,637	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,696	442,539	0.010611	254,949	2,705	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,066	2,783,514	0.014394	1,497,124	21,550	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	57,290	3,914,525	0.014635	802,796	11,749	73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	24,247	697,382	0.034769	0	0	76.01
76.02	03950	IV THERAPY	0	0	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
90.00	09000	CLINIC	59,139	591,260	0.100022	0	0	90.00
90.01	09001	OB CLINIC	67,249	177,042	0.379848	0	0	90.01
90.02	09002	SPECIALTY CLINIC	10,547	6,199	1.701403	0	0	90.02
90.03	09003	SURGICAL CLINIC	8,816	622,439	0.014164	0	0	90.03
91.00	09100	EMERGENCY	232,977	4,442,581	0.052442	1,657	87	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	70,018	543,778	0.128762	9,186	1,183	92.00
200.00		Total (lines 50-199)	2,533,771	65,473,147		7,636,222	199,204	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D Part IV | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0	90.03
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: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D Part IV Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,970,295	0.000000	0.000000	2,377,848	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	521,490	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,470,408	0.000000	0.000000	403,618	54.00
60.00	06000	LABORATORY	0	8,313,204	0.000000	0.000000	481,814	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	322,220	0.000000	0.000000	135,994	62.00
64.00	06400	INTRAVENOUS THERAPY	0	3,619,087	0.000000	0.000000	1,254,990	64.00
66.00	06600	PHYSICAL THERAPY	0	4,525,232	0.000000	0.000000	180,139	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,537,950	0.000000	0.000000	106,244	67.00
68.00	06800	SPEECH PATHOLOGY	0	198,581	0.000000	0.000000	16,861	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,773,421	0.000000	0.000000	113,002	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	442,539	0.000000	0.000000	254,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,783,514	0.000000	0.000000	1,497,124	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,914,525	0.000000	0.000000	802,796	73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	697,382	0.000000	0.000000	0	76.01
76.02	03950	IV THERAPY	0	0	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	591,260	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	177,042	0.000000	0.000000	0	90.01
90.02	09002	SPECIALTY CLINIC	0	6,199	0.000000	0.000000	0	90.02
90.03	09003	SURGICAL CLINIC	0	622,439	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	4,442,581	0.000000	0.000000	1,657	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	543,778	0.000000	0.000000	9,186	92.00
200.00		Total (lines 50-199)	0	65,473,147			7,636,222	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D Part IV | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
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	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.02	03950	IV THERAPY	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OB CLINIC	0	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0	0		90.03
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: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D Part V Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.328831	0	2,624,711	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.286807	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.250652	0	4,489,480	0	0	54.00
60.00	06000	LABORATORY	0.280292	0	2,807,243	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.497427	0	84,224	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.029478	0	398,975	1,470	0	64.00
66.00	06600	PHYSICAL THERAPY	0.487938	0	1,088,859	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.503894	0	189,016	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.778458	0	23,764	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.244542	0	1,351,927	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.106402	0	31,538	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.556600	0	138,634	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.402917	0	943,192	2,678	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.276341	0	217,950	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.146578	0	68,559	67	0	90.00
90.01	09001	OB CLINIC	0.912975	0	7,649	1	0	90.01
90.02	09002	SPECIALTY CLINIC	2.892725	0	5,982	0	0	90.02
90.03	09003	SURGICAL CLINIC	0.402417	0	4,822	0	0	90.03
91.00	09100	EMERGENCY	0.552693	0	1,464,190	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.010085	0	268,549	0	0	92.00
200.00		Subtotal (see instructions)		0	16,209,264	4,216	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	16,209,264	4,216	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D Part V Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	863,086	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,125,297	0	54.00
60.00	06000	LABORATORY	786,848	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	41,895	0	62.00
64.00	06400	INTRAVENOUS THERAPY	11,761	43	64.00
66.00	06600	PHYSICAL THERAPY	531,296	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	95,244	0	67.00
68.00	06800	SPEECH PATHOLOGY	18,499	0	68.00
69.00	06900	ELECTROCARDIOLOGY	330,603	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,356	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	77,164	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	380,028	1,079	73.00
76.00	03020	ACUPUNCTURE	0	0	76.00
76.01	03610	SLEEP LAB	60,229	0	76.01
76.02	03950	IV THERAPY	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	78,608	77	90.00
90.01	09001	OB CLINIC	6,983	1	90.01
90.02	09002	SPECIALTY CLINIC	17,304	0	90.02
90.03	09003	SURGICAL CLINIC	1,940	0	90.03
91.00	09100	EMERGENCY	809,248	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	271,257	0	92.00
200.00		Subtotal (see instructions)	5,510,646	1,200	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	5,510,646	1,200	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141319 | Component CCN: 14Z319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D Part V | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.328831	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.286807	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.250652	0	0	0	0	54.00
60.00	06000	LABORATORY	0.280292	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.497427	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.029478	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.487938	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.503894	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.778458	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.244542	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.106402	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.556600	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.402917	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.276341	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.146578	0	0	0	0	90.00
90.01	09001	OB CLINIC	0.912975	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	2.892725	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0.402417	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.552693	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.010085	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: 141319 | Component CCN: 14Z319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D Part V | Date/Time Prepared: 10/17/2015 11:48 am

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OB CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0		90.03
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/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D Part IV | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Skilled Nursing Facility | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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	03020	ACUPUNCTURE	0	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0	0	0	0	0	76.01
76.02	03950	IV THERAPY	0	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OB CLINIC	0	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	0	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0	0	0	0	0	90.03
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: 141319 | Component CCN: 145464 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D Part IV | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Skilled Nursing Facility | 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	14,970,295	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	521,490	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,470,408	0.000000	0.000000	8,146	54.00
60.00	06000	LABORATORY	0	8,313,204	0.000000	0.000000	8,635	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	322,220	0.000000	0.000000	2,061	62.00
64.00	06400	INTRAVENOUS THERAPY	0	3,619,087	0.000000	0.000000	20,119	64.00
66.00	06600	PHYSICAL THERAPY	0	4,525,232	0.000000	0.000000	254,781	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,537,950	0.000000	0.000000	170,235	67.00
68.00	06800	SPEECH PATHOLOGY	0	198,581	0.000000	0.000000	33,215	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,773,421	0.000000	0.000000	275	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	442,539	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,783,514	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,914,525	0.000000	0.000000	93,887	73.00
76.00	03020	ACUPUNCTURE	0	0	0.000000	0.000000	0	76.00
76.01	03610	SLEEP LAB	0	697,382	0.000000	0.000000	0	76.01
76.02	03950	IV THERAPY	0	0	0.000000	0.000000	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	591,260	0.000000	0.000000	0	90.00
90.01	09001	OB CLINIC	0	177,042	0.000000	0.000000	0	90.01
90.02	09002	SPECIALTY CLINIC	0	6,199	0.000000	0.000000	0	90.02
90.03	09003	SURGICAL CLINIC	0	622,439	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	4,442,581	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	543,778	0.000000	0.000000	128	92.00
200.00		Total (lines 50-199)	0	65,473,147			591,482	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D Part IV | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Skilled Nursing Facility | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
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	03020	ACUPUNCTURE	0	0	0		76.00
76.01	03610	SLEEP LAB	0	0	0		76.01
76.02	03950	IV THERAPY	0	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	OB CLINIC	0	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0	0		90.03
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: 141319 | Component CCN: 145464 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D Part V | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Skilled Nursing Facility | PPS

		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	0.328831	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.286807	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.250652	0	0	0	0	54.00
60.00	06000	LABORATORY	0.280292	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.497427	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0.029478	0	0	0	0	64.00
66.00	06600	PHYSICAL THERAPY	0.487938	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.503894	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.778458	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.244542	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.106402	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.556600	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.402917	0	0	0	0	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	0	0	76.00
76.01	03610	SLEEP LAB	0.276341	0	0	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.146578	0	0	0	0	90.00
90.01	09001	OB CLINIC	0.912975	0	0	0	0	90.01
90.02	09002	SPECIALTY CLINIC	2.892725	0	0	0	0	90.02
90.03	09003	SURGICAL CLINIC	0.402417	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.552693	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.010085	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: 141319 | Component CCN: 145464 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D Part V | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Skilled Nursing Facility | PPS

		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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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	03020	ACUPUNCTURE	0	0		76.00
76.01	03610	SLEEP LAB	0	0		76.01
76.02	03950	IV THERAPY	0	0		76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OB CLINIC	0	0		90.01
90.02	09002	SPECIALTY CLINIC	0	0		90.02
90.03	09003	SURGICAL CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D-1 | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,814	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,361	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)	3,785	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	247	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)	176	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	18	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)	12	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,972	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)	199	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)	142	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,565,951	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)	2,422	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)	1,614	25.00
26.00	Total swing-bed cost (see instructions)	407,400	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,158,551	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,158,551	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)	953.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,880,460	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,880,460	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D-1 | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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)	2,499,043	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,379,503	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)	189,762	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	135,408	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	325,170	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/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR 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)	576	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	953.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	549,262	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D-1 | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	530,121	4,158,551	0.127477	549,262	70,018	90.00
91.00	Nursing School cost	0	4,158,551	0.000000	549,262	0	91.00
92.00	Allied health cost	0	4,158,551	0.000000	549,262	0	92.00
93.00	All other Medical Education	0	4,158,551	0.000000	549,262	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2014 To 05/31/2015	Worksheet D-1 Date/Time Prepared: 10/17/2015 11:48 am
	Title XVIII	Skilled Nursing Facility	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)	12,579	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	12,579	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)	12,579	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,023	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)	2,696,816	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,696,816	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)	2,696,816	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141319 | Component CCN: 145464 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D-1 | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Skilled Nursing Facility | 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)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	2,696,816	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	214.39	71.00
72.00	Program routine service cost (line 9 x line 71)	219,321	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	219,321	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	219,321	83.00
84.00	Program inpatient ancillary services (see instructions)	280,058	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	499,379	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2014 To 05/31/2015	Worksheet D-1 Date/Time Prepared: 10/17/2015 11:48 am
	Title XVIII	Skilled Nursing Facility	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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D-3 | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,738,402		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.328831	2,377,848	781,910	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.286807	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.250652	403,618	101,168	54.00
60.00	06000	LABORATORY	0.280292	481,814	135,049	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.497427	135,994	67,647	62.00
64.00	06400	INTRAVENOUS THERAPY	0.029478	1,254,990	36,995	64.00
66.00	06600	PHYSICAL THERAPY	0.487938	180,139	87,897	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.503894	106,244	53,536	67.00
68.00	06800	SPEECH PATHOLOGY	0.778458	16,861	13,126	68.00
69.00	06900	ELECTROCARDIOLOGY	0.244542	113,002	27,634	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.106402	254,949	27,127	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.556600	1,497,124	833,299	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.402917	802,796	323,460	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.276341	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.146578	0	0	90.00
90.01	09001	OB CLINIC	0.912975	0	0	90.01
90.02	09002	SPECIALTY CLINIC	2.892725	0	0	90.02
90.03	09003	SURGICAL CLINIC	0.402417	0	0	90.03
91.00	09100	EMERGENCY	0.552693	1,657	916	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.010085	9,186	9,279	92.00
200.00		Total (sum of lines 50-94 and 96-98)		7,636,222	2,499,043	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)		7,636,222		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141319 | Component CCN: 14Z319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D-3 | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.328831	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.286807	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.250652	11,236	2,816	54.00
60.00	06000	LABORATORY	0.280292	21,200	5,942	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.497427	1,031	513	62.00
64.00	06400	INTRAVENOUS THERAPY	0.029478	52,706	1,554	64.00
66.00	06600	PHYSICAL THERAPY	0.487938	79,829	38,952	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.503894	48,331	24,354	67.00
68.00	06800	SPEECH PATHOLOGY	0.778458	6,979	5,433	68.00
69.00	06900	ELECTROCARDIOLOGY	0.244542	3,811	932	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.106402	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.556600	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.402917	61,773	24,889	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.276341	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.146578	0	0	90.00
90.01	09001	OB CLINIC	0.912975	0	0	90.01
90.02	09002	SPECIALTY CLINIC	2.892725	0	0	90.02
90.03	09003	SURGICAL CLINIC	0.402417	0	0	90.03
91.00	09100	EMERGENCY	0.552693	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.010085	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		286,896	105,385	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)		286,896		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet D-3

Component CCN: 145464 | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Skilled Nursing Facility | 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
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.328831	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.286807	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.250652	8,146	2,042	54.00
60.00	06000	LABORATORY	0.280292	8,635	2,420	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.497427	2,061	1,025	62.00
64.00	06400	INTRAVENOUS THERAPY	0.029478	20,119	593	64.00
66.00	06600	PHYSICAL THERAPY	0.487938	254,781	124,317	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.503894	170,235	85,780	67.00
68.00	06800	SPEECH PATHOLOGY	0.778458	33,215	25,856	68.00
69.00	06900	ELECTROCARDIOLOGY	0.244542	275	67	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.106402	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.556600	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.402917	93,887	37,829	73.00
76.00	03020	ACUPUNCTURE	0.000000	0	0	76.00
76.01	03610	SLEEP LAB	0.276341	0	0	76.01
76.02	03950	IV THERAPY	0.000000	0	0	76.02
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.146578	0	0	90.00
90.01	09001	OB CLINIC	0.912975	0	0	90.01
90.02	09002	SPECIALTY CLINIC	2.892725	0	0	90.02
90.03	09003	SURGICAL CLINIC	0.402417	0	0	90.03
91.00	09100	EMERGENCY	0.552693	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.010085	128	129	92.00
200.00		Total (sum of lines 50-94 and 96-98)		591,482	280,058	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)		591,482		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319	Period: From 06/01/2014 To 05/31/2015	Worksheet E Part B Date/Time Prepared: 10/17/2015 11:48 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,511,846	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)	5,511,846	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, line 69, col. 4)	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)	5,566,964	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)	57,185	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,658,273	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} (for CAH, see instructions)	2,851,506	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,851,506	30.00
31.00	Primary payer payments	3	31.00
32.00	Subtotal (line 30 minus line 31)	2,851,503	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)	99,058	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	75,284	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	88,794	36.00
37.00	Subtotal (see instructions)	2,926,787	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,926,787	40.00
40.01	Sequestration adjustment (see instructions)	58,536	40.01
41.00	Interim payments	2,837,557	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	30,694	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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2014 To 05/31/2015	Worksheet E Part B Date/Time Prepared: 10/17/2015 11:48 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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} (for CAH, see instructions)	0	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)	0	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	0	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	0	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
41.00	Interim payments	0	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,367,263		3,318,252	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	12/29/2014	56,213		0	3.01
3.02		05/26/2015	265,660		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	12/29/2014	83,958	3.50
3.51			0	05/26/2015	396,737	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)		321,873		-480,695	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)		3,689,136		2,837,557	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		86,990		30,694	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,776,126		2,868,251	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: 141319 | Component CCN: 14Z319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		395,448		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	05/26/2015	17,022		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	12/29/2014	3,271		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)		13,751		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)		409,199		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		14,581		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		423,780		0	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: 141319 | Component CCN: 145464 | Period: From 06/01/2014 To 05/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 10/17/2015 11:48 am

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		345,119		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		345,119		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		345,119		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: 141319	Period: From 06/01/2014 To 05/31/2015	Worksheet E-1 Part II Date/Time Prepared: 10/17/2015 11:48 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1,365	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,972	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	237	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	3,785	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	72,754,474	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	352,796	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141319 Component CCN: 14Z319	Period: From 06/01/2014 To 05/31/2015	Worksheet E-2 Date/Time Prepared: 10/17/2015 11:48 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	328,422	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 Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	106,439	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	341	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)	434,861	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	434,861	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)	434,861	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,432	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)	432,429	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)	432,429	0	19.00
19.01	Sequestration adjustment (see instructions)	8,649	0	19.01
20.00	Interim payments	409,199	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)	14,581	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319	Period: From 06/01/2014 To 05/31/2015	Worksheet E-3 Part V Date/Time Prepared: 10/17/2015 11:48 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,379,503	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)	4,379,503	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,423,298	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)	4,423,298	19.00
20.00	Deductibles (exclude professional component)	590,445	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,832,853	22.00
23.00	Coinsurance	2,813	23.00
24.00	Subtotal (line 22 minus line 23)	3,830,040	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	30,461	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	23,150	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	28,121	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,853,190	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)	3,853,190	30.00
30.01	Sequestration adjustment (see instructions)	77,064	30.01
31.00	Interim payments	3,689,136	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)	86,990	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141319 Component CCN: 145464	Period: From 06/01/2014 To 05/31/2015	Worksheet E-3 Part VI Date/Time Prepared: 10/17/2015 11:48 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	412,995	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	412,995	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	57,543	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	355,452	12.00
13.00	Inpatient primary payer payments	3,290	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	352,162	15.00
15.01	Sequestration adjustment (see instructions)	7,043	15.01
16.00	Interim payments	345,119	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet G | Date/Time Prepared: 10/17/2015 11:48 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	5,371,137	0	0	0	1.00
2.00	Temporary investments	1,037,915	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	4,266,020	0	0	0	4.00
5.00	Other receivable	174,379	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	904,961	0	0	0	7.00
8.00	Prepaid expenses	331,425	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	868,240	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	12,954,077	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	33,514,462	0	0	0	15.00
16.00	Accumulated depreciation	0	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	33,514,462	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	13,183,753	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	3,623,462	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	16,807,215	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	63,275,754	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,329,153	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,647,042	0	0	0	38.00
39.00	Payroll taxes payable	456,034	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,309,113	0	0	0	40.00
41.00	Deferred income	1,847,381	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,105	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,591,828	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	25,476,618	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	542,095	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	26,018,713	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	32,610,541	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	30,665,213				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)	30,665,213	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	63,275,754	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet G-1 | Date/Time Prepared: 10/17/2015 11:48 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		29,480,801		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1,184,412				2.00
3.00	Total (sum of line 1 and line 2)		30,665,213		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		30,665,213		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		30,665,213		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 10/17/2015 11:48 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	4,078,406		4,078,406	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	2,348,226		2,348,226	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,426,632		6,426,632	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)	6,426,632		6,426,632	17.00
18.00	Ancillary services	16,723,739	44,303,408	61,027,147	18.00
19.00	Outpatient services	329,591	10,889,973	11,219,564	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		980,409	980,409	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	417,391	672	418,063	27.00
27.01	NRCC CLINICS	0	2,662	2,662	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	23,897,353	56,177,124	80,074,477	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,729,846		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		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)		34,729,846		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141319 | Period: From 06/01/2014 To 05/31/2015 | Worksheet G-3 | Date/Time Prepared: 10/17/2015 11:48 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	80,074,477	1.00
2.00	Less contractual allowances and discounts on patients' accounts	43,877,896	2.00
3.00	Net patient revenues (line 1 minus line 2)	36,196,581	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	34,729,846	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,466,735	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	86,256	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	683,227	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.01	EHR PAYMENTS	81,075	24.01
24.02	OTHER OP REV	678,531	24.02
24.03	CAPITAL CONTRIBUTIONS	315,113	24.03
25.00	Total other income (sum of lines 6-24)	1,844,202	25.00
26.00	Total (line 5 plus line 25)	3,310,937	26.00
27.00	LOSS ON DISPOSAL	22,656	27.00
27.01	CHARITY CARE	152,744	27.01
27.02	LOSS ON INVESTMENT	841,670	27.02
27.03	BAD DEBTS	1,109,455	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	2,126,525	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	1,184,412	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141319 | HHA CCN: 147450 | Period: From 06/01/2014 To 05/31/2015 | Worksheet H | Date/Time Prepared: 10/17/2015 11:48 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	101,696	0	1,882	21,152	7,485	132,215	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	363,025	0	59,788	0	0	422,813	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	37,660	0	0	0	0	37,660	11.00
12.00	Supplies (see instructions)	0	0	0	0	31,247	31,247	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	502,381	0	61,670	21,152	38,732	623,935	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	132,215	-2,662	129,553			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	422,813	0	422,813			6.00
7.00	Physical Therapy	0	0	0	0			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	0	0	0			10.00
11.00	Home Health Aide	0	37,660	0	37,660			11.00
12.00	Supplies (see instructions)	0	31,247	0	31,247			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	623,935	-2,662	621,273			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 141319 HHA CCN: 147450 | Period: From 06/01/2014 To 05/31/2015 | Worksheet H-1 Part I Date/Time Prepared: 10/17/2015 11:48 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	129,553	0	0	0	0	129,553	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	422,813	0	0	0	0	422,813	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	37,660	0	0	0	0	37,660	11.00
12.00	Supplies (see instructions)	31,247	0	0	0	0	31,247	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	621,273	0	0	0	0	621,273	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	129,553		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	111,398	534,211	6.00
7.00	Physical Therapy	0	0	7.00
8.00	Occupational Therapy	0	0	8.00
9.00	Speech Pathology	0	0	9.00
10.00	Medical Social Services	0	0	10.00
11.00	Home Health Aide	9,922	47,582	11.00
12.00	Supplies (see instructions)	8,233	39,480	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		621,273	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 141319 HHA CCN: 147450 | Period: From 06/01/2014 To 05/31/2015 | Worksheet H-1 Part II Date/Time Prepared: 10/17/2015 11:48 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-129,553	491,720	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	422,813	6.00
7.00	Physical Therapy	0	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	37,660	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	31,247	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-129,553	491,720	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		129,553	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.263469	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141319 | HHA CCN: 147450 | Period: From 06/01/2014 To 05/31/2015 | Worksheet H-2 Part I | Date/Time Prepared: 10/17/2015 11:48 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	DATA PROCESSING	PURCHASING RECEIVING AND STORES	
		0	1.00	2.00	4.00	5.01	5.02	
1.00	Administrative and General	0	25,633	268	156,926	24,014	2,199	1.00
2.00	Skilled Nursing Care	534,211	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	47,582	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	39,480	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	621,273	25,633	268	156,926	24,014	2,199	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	ADMITTING	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		5.03	5.04	5A.04	5.05	7.00	8.00	
1.00	Administrative and General	0	6,855	215,895	18,826	17,925	0	1.00
2.00	Skilled Nursing Care	0	0	534,211	46,583	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	47,582	4,149	0	0	7.00
8.00	Supplies (see instructions)	0	0	39,480	3,443	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	6,855	837,168	73,001	17,925	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.000000				21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141319 | HHA CCN: 147450 | Period: From 06/01/2014 To 05/31/2015 | Worksheet H-2 Part I | Date/Time Prepared: 10/17/2015 11:48 am

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	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9.00	10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	4,965	0	0	45,952	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	4,965	0	0	45,952	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE INSERVICE EDUCATION	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		16.00	17.00	18.00	24.00	25.00	26.00	
1.00	Administrative and General	0	4,166	0	307,729	0	307,729	1.00
2.00	Skilled Nursing Care	0	0	0	580,794	0	580,794	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	51,731	0	51,731	7.00
8.00	Supplies (see instructions)	0	0	0	42,923	0	42,923	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	4,166	0	983,177	0	983,177	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141319 | HHA CCN: 147450 | Period: From 06/01/2014 To 05/31/2015 | Worksheet H-2 Part I | Date/Time Prepared: 10/17/2015 11:48 am

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	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	264,606	845,400	2.00
3.00	Physical Therapy	0	0	3.00
4.00	Occupational Therapy	0	0	4.00
5.00	Speech Pathology	0	0	5.00
6.00	Medical Social Services	0	0	6.00
7.00	Home Health Aide	23,568	75,299	7.00
8.00	Supplies (see instructions)	19,555	62,478	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	307,729	983,177	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.455592		21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141319 HHA CCN: 147450

Period: From 06/01/2014 To 05/31/2015

Worksheet H-2 Part II Date/Time Prepared: 10/17/2015 11:48 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	DATA PROCESSING (TIME SPENT)	PURCHASING RECEIVING AND STORES (SUPPLY COST)	ADMITTING (GROSS CHARGES)	
		1.00	2.00	4.00	5.01	5.02	5.03	
1.00	Administrative and General	1,008	247	502,381	3,685	36,257	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	1,008	247	502,381	3,685	36,257	0	20.00
21.00	Total cost to be allocated	25,633	268	156,926	24,014	2,199	0	21.00
22.00	Unit cost multiplier	25.429563	1.085020	0.312365	6.516689	0.060650	0.000000	22.00

	Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (GROSS CHARGES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
		5.04	5A.05	5.05	7.00	8.00	9.00	
1.00	Administrative and General	980,409	0	215,895	1,008	0	4,260	1.00
2.00	Skilled Nursing Care	0	0	534,211	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	47,582	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	39,480	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	980,409		837,168	1,008	0	4,260	20.00
21.00	Total cost to be allocated	6,855		73,001	17,925	0	4,965	21.00
22.00	Unit cost multiplier	0.006992		0.087200	17.782738	0.000000	1.165493	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141319 HHA CCN: 147450

Period: From 06/01/2014 To 05/31/2015

Worksheet H-2 Part II Date/Time Prepared: 10/17/2015 11:48 am

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	Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (FTE'S)	CENTRAL SERVICES & SUPPLY (COSTED REQ UIS)	PHARMACY (COSTED REQ UIS)	MEDICAL RECORDS & LIBRARY (GROSS PT. CHARGES)	
		10.00	11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	908	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	908	0	0	0	20.00
21.00	Total cost to be allocated	0	0	45,952	0	0	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	50.607930	0.000000	0.000000	0.000000	22.00

	Cost Center Description	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE INSERVICE EDUCATION (GROSS CHARGES)					
		17.00	18.00					
1.00	Administrative and General	1,325	0					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19)	1,325	0					20.00
21.00	Total cost to be allocated	4,166	0					21.00
22.00	Unit cost multiplier	3.144151	0.000000					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 141319 | HHA CCN: 147450 | Period: From 06/01/2014 To 05/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 10/17/2015 11:48 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	845,400		845,400	5,949	142.11	1.00
2.00	Physical Therapy	3.00	0	172,383	172,383	2,103	81.97	2.00
3.00	Occupational Therapy	4.00	0	108,010	108,010	1,244	86.82	3.00
4.00	Speech Pathology	5.00	0	24,197	24,197	201	120.38	4.00
5.00	Medical Social Services	6.00	0		0	13	0.00	5.00
6.00	Home Health Aide	7.00	75,299		75,299	1,792	42.02	6.00
7.00	Total (sum of lines 1-6)		920,699	304,590	1,225,289	11,302		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits				
				Part A	Part B			
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		19340	0	4,513			8.00
8.01	Skilled Nursing Care		37900	0	0			8.01
8.02	Skilled Nursing Care		99914	0	161			8.02
8.03	Skilled Nursing Care		50208	0	0			8.03
8.04	Skilled Nursing Care		49740	0	0			8.04
9.00	Physical Therapy		19340	0	1,381			9.00
9.01	Physical Therapy		37900	0	0			9.01
9.02	Physical Therapy		99914	0	55			9.02
9.03	Physical Therapy		50208	0	0			9.03
9.04	Physical Therapy		49740	0	0			9.04
10.00	Occupational Therapy		19340	0	884			10.00
10.01	Occupational Therapy		37900	0	0			10.01
10.02	Occupational Therapy		99914	0	69			10.02
10.03	Occupational Therapy		50208	0	0			10.03
10.04	Occupational Therapy		49740	0	0			10.04
11.00	Speech Pathology		19340	0	173			11.00
11.01	Speech Pathology		37900	0	0			11.01
11.02	Speech Pathology		99914	0	4			11.02
11.03	Speech Pathology		50208	0	0			11.03
11.04	Speech Pathology		49740	0	0			11.04
12.00	Medical Social Services		19340	0	13			12.00
12.01	Medical Social Services		37900	0	0			12.01
12.02	Medical Social Services		99914	0	0			12.02
12.03	Medical Social Services		50208	0	0			12.03
12.04	Medical Social Services		49740	0	0			12.04
13.00	Home Health Aide		19340	0	1,364			13.00
13.01	Home Health Aide		37900	0	0			13.01
13.02	Home Health Aide		99914	0	81			13.02
13.03	Home Health Aide		50208	0	0			13.03
13.04	Home Health Aide		49740	0	0			13.04
14.00	Total (sum of lines 8-13)			0	8,698			14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

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	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	62,478	0	62,478	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	4,674		0	664,222		1.00
2.00	Physical Therapy	0	1,436		0	117,709		2.00
3.00	Occupational Therapy	0	953		0	82,739		3.00
4.00	Speech Pathology	0	177		0	21,307		4.00
5.00	Medical Social Services	0	13		0	0		5.00
6.00	Home Health Aide	0	1,445		0	60,719		6.00
7.00	Total (sum of lines 1-6)	0	8,698		0	946,696		7.00

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
8.04	Skilled Nursing Care							8.04
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
9.04	Physical Therapy							9.04
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
10.04	Occupational Therapy							10.04
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
11.04	Speech Pathology							11.04
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
12.04	Medical Social Services							12.04
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
13.03	Home Health Aide							13.03
13.04	Home Health Aide							13.04
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141319 | HHA CCN: 147450 | Period: From 06/01/2014 To 05/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 10/17/2015 11:48 am

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	664,222						1.00
2.00	Physical Therapy	117,709						2.00
3.00	Occupational Therapy	82,739						3.00
4.00	Speech Pathology	21,307						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	60,719						6.00
7.00	Total (sum of lines 1-6)	946,696						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
8.02	Skilled Nursing Care							8.02
8.03	Skilled Nursing Care							8.03
8.04	Skilled Nursing Care							8.04
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
9.02	Physical Therapy							9.02
9.03	Physical Therapy							9.03
9.04	Physical Therapy							9.04
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
10.02	Occupational Therapy							10.02
10.03	Occupational Therapy							10.03
10.04	Occupational Therapy							10.04
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
11.02	Speech Pathology							11.02
11.03	Speech Pathology							11.03
11.04	Speech Pathology							11.04
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
12.02	Medical Social Services							12.02
12.03	Medical Social Services							12.03
12.04	Medical Social Services							12.04
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
13.02	Home Health Aide							13.02
13.03	Home Health Aide							13.03
13.04	Home Health Aide							13.04
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141319 | HHA CCN: 147450 | Period: From 06/01/2014 To 05/31/2015 | Worksheet H-3 Part II | Date/Time Prepared: 10/17/2015 11:48 am

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.487938	353,288	172,383	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.503894	214,351	108,010	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.778458	31,083	24,197	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.106402	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.402917	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141319 | HHA CCN: 147450 | Period: From 06/01/2014 To 05/31/2015 | Worksheet H-4 Part I-II | Date/Time Prepared: 10/17/2015 11:48 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	302,635	566,832	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	302,635	566,832	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	302,635	566,832	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	5,362	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	-5,362	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,012,208	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	38,219	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	17,352	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	10,846	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	7,460	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	798	16.00
17.00	Total Other Payments	0	2,439	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,083,960	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,083,960	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	1,083,960	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	1,083,960	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	1,083,960	31.00
31.01	Sequestration adjustment (see instructions)	0	26,459	31.01
32.00	Interim payments (see instructions)	0	1,057,501	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	35.00

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

Provider CCN: 141319 HHA CCN: 147450

Period: From 06/01/2014 To 05/31/2015

Worksheet H-5

Date/Time Prepared: 10/17/2015 11:48 am

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		1,057,501	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		1,057,501	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,057,501	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00