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: 140001	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/20/2015 12:37 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/20/2015 Time: 12:37 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 GRAHAM HOSPITAL ASSOCIATION (140001) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	201,400	8,317	-18,091	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	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	201,150	89		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	153		0	9.00
10.00	RURAL HEALTH CLINIC I	0		-31,094		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	402,550	-22,535	-18,091	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: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2015 10:22 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 210 WEST WALNUT	PO Box:			1.00
2.00	City: CANTON	State: IL	Zip Code: 61520-	County: FULTON	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	GRAHAM HOSPITAL ASSOCIATION	140001	99914	1	07/19/1966	N	P	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N	P	N	9.00
10.00	Hospital-Based NF	GRAHAM HOSPITAL ASSOCIATION ECF	145572	99914		07/02/1987	N		O	10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	GRAHAM HOSPITAL HOME HEALTH AGENCY	147142	99914		06/01/1979	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	GRAHAM HOSPITAL HOSPICE	141558	99914		07/28/1993				14.00
15.00	Hospital-Based Health Clinic - RHC	COLEMAN CLINIC	143493	99914		01/01/2008	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2014	06/30/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	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)	Y	Y	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.	1,601	0	0	0	183	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2015 10:22 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	1		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.	07/01/2014	06/30/2015	36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	Y	Y	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y			60.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/20/2015 10:22 am

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 10:22 am

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

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

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

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

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

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	N		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)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	414,826	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.	Y	Y	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/20/2015 10:22 am

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

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.50	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2014	06/30/2015	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: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2015 10:22 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?		Y	Y	6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	10/22/2015	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2015 10:22 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				N	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.	ANN	SHOWERS	41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563.888.4441	ANN.SHOWERS@RSMUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/20/2015 10:22 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)	10/22/2015			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.		SUPERVISOR		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

HFS Supplemental Information | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part IX | Date/Time Prepared: 11/20/2015 10:22 am

		Title V	Title XIX	
		1.00	2.00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE			
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	3.00
		Inpatient	Outpatient	
		1.00	2.00	
	CRITICAL ACCESS HOSPITALS			
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.	N	N	5.00
		Title V	Title XIX	
		1.00	2.00	
	RCE DISALLOWANCE			
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	6.00
	PASS THROUGH COST			
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "O") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.	Y	Y	7.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2015 10:22 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	38	13,870	0.00	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)		38	13,870	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	5	1,825	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		43	15,695	0.00	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	20	7,300		0	19.00
20.00	NURSING FACILITY	45.00	18	6,570		0	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		81				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: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2015 10:22 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)	2,944	1,164	6,362			1.00
2.00	HMO and other (see instructions)	1,299	183				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	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,944	1,164	6,362			7.00
8.00	INTENSIVE CARE UNIT	442	115	843			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		322	505			13.00
14.00	Total (see instructions)	3,386	1,601	7,710	0.00	449.82	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	3,191	219	4,778	0.00	18.79	19.00
20.00	NURSING FACILITY		3,957	5,740	0.00	17.24	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,032	0	4,325	0.00	9.07	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	2.59	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	17,329	0	92,087	0.00	69.63	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	567.14	27.00
28.00	Observation Bed Days		0	1,102			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			67			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/20/2015 10:22 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	876	430	2,090	1.00
2.00	HMO and other (see instructions)			312	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	876	430	2,090	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	0.00					20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part II | Date/Time Prepared: 11/20/2015 10:22 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	28,421,329	0	28,421,329	1,179,639.00	24.09	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		1,171,310	0	1,171,310	10,400.00	112.63	3.00
4.00	Physician-Part A - Administrative		21,916	0	21,916	86.00	254.84	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		2,139,822	0	2,139,822	25,369.00	84.35	5.00
6.00	Non-physician-Part B		2,358,008	0	2,358,008	131,284.00	17.96	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	856,996	0	856,996	39,079.00	21.93	9.00
10.00	Excluded area salaries (see instructions)		2,281,008	178,694	2,459,702	107,020.00	22.98	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,491,058	0	1,491,058	29,685.88	50.23	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		5,708,934	0	5,708,934			17.00
18.00	Wage-related costs (other) (see instructions)		120,607	0	120,607			18.00
19.00	Excluded areas		954,393	0	954,393			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		143,732	0	143,732			21.00
22.00	Physician Part A - Administrative		20,778	0	20,778			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		300,724	0	300,724			23.00
24.00	Wage-related costs (RHC/FQHC)		821,494	0	821,494			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	165,417	0	165,417	7,220.00	22.91	26.00
27.00	Administrative & General	5.00	5,480,703	0	5,480,703	227,815.00	24.06	27.00
28.00	Administrative & General under contract (see inst.)		1,652,963	0	1,652,963	16,297.00	101.43	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	807,494	-1,906	805,588	49,334.00	16.33	30.00
31.00	Laundry & Linen Service	8.00	25,548	0	25,548	2,517.00	10.15	31.00
32.00	Housekeeping	9.00	705,343	0	705,343	60,761.00	11.61	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	562,194	-314,851	247,343	19,851.00	12.46	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	314,851	314,851	25,269.00	12.46	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	428,448	0	428,448	13,174.00	32.52	38.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part II | Date/Time Prepared: 11/20/2015 10:22 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
39.00	Central Services and Supply	14.00	54,319	0	54,319	4,202.00	12.93	39.00
40.00	Pharmacy	15.00	714,449	0	714,449	25,413.00	28.11	40.00
41.00	Medical Records & Medical Records Library	16.00	447,292	0	447,292	42,111.00	10.62	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 11/20/2015 10:22 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		24,405,152	0	24,405,152	1,028,883.00	23.72	1.00
2.00	Excluded area salaries (see instructions)		3,138,004	178,694	3,316,698	146,099.00	22.70	2.00
3.00	Subtotal salaries (line 1 minus line 2)		21,267,148	-178,694	21,088,454	882,784.00	23.89	3.00
4.00	Subtotal other wages & related costs (see inst.)		1,491,058	0	1,491,058	29,685.88	50.23	4.00
5.00	Subtotal wage-related costs (see inst.)		5,850,319	0	5,850,319	0.00	27.74	5.00
6.00	Total (sum of lines 3 thru 5)		28,608,525	-178,694	28,429,831	912,469.88	31.16	6.00
7.00	Total overhead cost (see instructions)		11,044,170	-1,906	11,042,264	493,964.00	22.35	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part IV | Date/Time Prepared: 11/20/2015 10:22 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	650,113	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	252,572	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	4,555,286	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	1,516	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	126,853	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	310,523	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,959,855	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	58,795	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	9,623	22.00
23.00	Tuition Reimbursement	136,825	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	8,061,961	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS	8,700	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part V | Date/Time Prepared: 11/20/2015 10:22 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	1,491,058	0	1.00
2.00	Hospital	827,565	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	470,028	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	193,465	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 140001 | Component CCN: 147142 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-4 | Date/Time Prepared: 11/20/2015 10:22 am

Home Health Agency I | PPS

						1.00	
0.00	County				MCLEAN		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	1,761	198	744	2,703	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	142.00	16.00	60.00	218.00	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	1.45	0.00	1.45	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			1.86	0.00	1.86	5.00
6.00	Direct Nursing Service			4.09	0.49	4.58	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.86	0.86	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.39	0.39	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.06	0.06	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.38	0.00	0.38	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.30	0.00	1.30	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	HOMEMAKER			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.			3			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
20.01				37900			20.01
20.02				44100			20.02
		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	806	159	70	6	1,041	21.00
22.00	Skilled Nursing Visit Charges	155,078	30,297	13,488	1,158	200,021	22.00
23.00	Physical Therapy Visits	352	0	47	0	399	23.00
24.00	Physical Therapy Visit Charges	73,766	0	9,842	0	83,608	24.00
25.00	Occupational Therapy Visits	207	0	4	0	211	25.00
26.00	Occupational Therapy Visit Charges	43,377	0	839	0	44,216	26.00
27.00	Speech Pathology Visits	39	0	0	0	39	27.00
28.00	Speech Pathology Visit Charges	8,180	0	0	0	8,180	28.00
29.00	Medical Social Service Visits	13	0	2	0	15	29.00
30.00	Medical Social Service Visit Charges	3,448	0	532	0	3,980	30.00
31.00	Home Health Aide Visits	305	18	0	4	327	31.00
32.00	Home Health Aide Visit Charges	36,891	2,178	0	484	39,553	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,722	177	123	10	2,032	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)	320,740	32,475	24,701	1,642	379,558	35.00
36.00	Total Number of Episodes (standard/non outlier)	124		47	1	172	36.00
37.00	Total Number of Outlier Episodes		5		0	5	37.00
38.00	Total Non-Routine Medical Supply Charges	31,750	9,820	5,543	0	47,113	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-7 | Date/Time Prepared: 11/20/2015 10:22 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.			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.	N		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	454	0	454	12.00
13.00		RUB	137	0	137	13.00
14.00		RUA	855	0	855	14.00
15.00		RVC	376	0	376	15.00
16.00		RVB	129	0	129	16.00
17.00		RVA	587	0	587	17.00
18.00		RHC	207	0	207	18.00
19.00		RHB	104	0	104	19.00
20.00		RHA	172	0	172	20.00
21.00		RMC	29	0	29	21.00
22.00		RMB	28	0	28	22.00
23.00		RMA	6	0	6	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	16	0	16	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	16	0	16	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	0	0	0	47.00
48.00		CD1	14	0	14	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	7	0	7	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	39	0	39	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	15	0	15	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: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-7 | Date/Time Prepared: 11/20/2015 10:22 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	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		3,191	0	3,191	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).	99916	99916	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	856,996	43.66	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	545	0.03	Y	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)	1,962,699			207.00

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

Provider CCN: 140001 Component CCN: 143493 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-8 | Date/Time Prepared: 11/20/2015 10:22 am

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			180 S MAIN STREET		1.00
		City		State	ZIP Code	
		1.00		2.00	3.00	
2.00	City, State, ZIP Code, County	CANTON		IL	61520	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic	08:30	15:00	07:30	17:30	07:30	11.00

				1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?			N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.			Y	4	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	FARMINGTON CLINIC	143494	14.00
14.01		CANTON CLINIC	143492	14.01
14.02		CUBA CLINIC	143497	14.02
14.03		COLEMAN CLINIC	143493	14.03

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

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

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

Provider CCN: 140001
Component CCN: 143493

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

Worksheet S-8

Date/Time Prepared:
11/20/2015 10:22 am

Rural Health Clinic (RHC) I

Cost

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:30	07:30	17:30	07:30	17:30	11.00

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:30	17:30	08:30	17:00		11.00

HOSPITAL IDENTIFICATION DATA | Provider CCN: 140001 Component CCN: 141558 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-9 Parts I & II Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

		Unduplicated Days Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0	0	0	0	1.00
2.00	Routine Home Care	1,265	15	0	0	22	1,302	2.00
3.00	Inpatient Respite Care	0	0	0	0	0	0	3.00
4.00	General Inpatient Care	7	0	0	0	0	7	4.00
5.00	Total Hospice Days	1,272	15	0	0	22	1,309	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	49	1	0	0	4	54	6.00
7.00	Total Number of Unduplicated Continuous Care Hours Billable to Medicare	0.00		0.00				7.00
8.00	Average Length of Stay (line 5/line 6)	25.96	15.00	0.00	0.00	5.50	24.24	8.00
9.00	Unduplicated Census Count	47	1	0	0	4	52	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 11/20/2015 10:22 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)	0.328672	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,182,598	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	3,245,045	5.00
6.00	Medicaid charges	45,242,025	6.00
7.00	Medicaid cost (line 1 times line 6)	14,869,787	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)	3,442,144	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)	3,442,144	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	2,625,148	1,142,942	3,768,090	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	862,813	375,653	1,238,466	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	862,813	375,653	1,238,466	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)	1,939,582	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	240,677	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,698,905	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	558,383	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,796,849	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,238,993	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/20/2015 10:22 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		6,868,693	6,868,693	-3,172,027	3,696,666	1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB		0	0	25,505	25,505	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	3,165,926	3,165,926	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	165,417	8,170,417	8,335,834	109,517	8,445,351	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,480,703	7,014,057	12,494,760	-218,072	12,276,688	5.00
7.00	00700	OPERATION OF PLANT	807,494	1,818,088	2,625,582	-1,906	2,623,676	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,548	243,857	269,405	0	269,405	8.00
9.00	00900	HOUSEKEEPING	705,343	149,456	854,799	0	854,799	9.00
10.00	01000	DIETARY	562,194	872,881	1,435,075	-803,699	631,376	10.00
11.00	01100	CAFETERIA	0	0	0	803,699	803,699	11.00
13.00	01300	NURSING ADMINISTRATION	428,448	18,396	446,844	0	446,844	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	54,319	350,329	404,648	-587,067	-182,419	14.00
15.00	01500	PHARMACY	714,449	103,401	817,850	0	817,850	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	447,292	132,750	580,042	0	580,042	16.00
20.00	02000	NURSING SCHOOL	1,019,991	190,246	1,210,237	38,895	1,249,132	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,443,930	109,027	2,552,957	0	2,552,957	30.00
31.00	03100	INTENSIVE CARE UNIT	622,593	43,197	665,790	0	665,790	31.00
43.00	04300	NURSERY	260,114	6,404	266,518	0	266,518	43.00
44.00	04400	SKILLED NURSING FACILITY	856,996	84,024	941,020	0	941,020	44.00
45.00	04500	NURSING FACILITY	616,949	15,305	632,254	0	632,254	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,452,810	2,327,372	3,780,182	-1,645,993	2,134,189	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	68,326	0	68,326	0	68,326	52.00
53.00	05300	ANESTHESIOLOGY	1,171,310	67,996	1,239,306	0	1,239,306	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	804,366	541,852	1,346,218	0	1,346,218	54.00
57.00	05700	CT SCAN	52,537	156,732	209,269	0	209,269	57.00
58.00	05800	MRI	52,387	125,642	178,029	0	178,029	58.00
60.00	06000	LABORATORY	1,504,418	1,745,249	3,249,667	0	3,249,667	60.00
65.00	06500	RESPIRATORY THERAPY	476,959	76,296	553,255	0	553,255	65.00
66.00	06600	PHYSICAL THERAPY	0	1,458,048	1,458,048	0	1,458,048	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,089,956	1,089,956	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,143,104	1,143,104	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,193,207	2,193,207	0	2,193,207	73.00
76.97	07697	CARDIAC REHABILITATION	236,764	43,748	280,512	0	280,512	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,238,188	9,024,825	12,263,013	-2,037,330	10,225,683	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	417,858	417,858	0	417,858	90.01
91.00	09100	EMERGENCY	3,119,493	227,998	3,347,491	0	3,347,491	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	387,923	674,486	1,062,409	30,815	1,093,224	96.00
101.00	10100	HOME HEALTH AGENCY	479,877	259,791	739,668	4,956	744,624	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		0	0	0	0	113.00
116.00	11600	HOSPICE	124,583	26,481	151,064	4,956	156,020	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,381,721	45,558,109	73,939,830	-2,048,765	71,891,065	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	39,608	5,870	45,478	2,039,236	2,084,714	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	748	748	0	748	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	9,529	9,529	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	19,130	19,130	0	19,130	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	45,783	45,783	0	45,783	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
200.00		TOTAL (SUM OF LINES 118-199)	28,421,329	45,629,640	74,050,969	0	74,050,969	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/20/2015 10:22 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	-920,071	2,776,595		1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	0	25,505		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-527	3,165,399		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-2,665,359	5,779,992		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,548,743	9,727,945		5.00
7.00	00700	OPERATION OF PLANT	-400	2,623,276		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	269,405		8.00
9.00	00900	HOUSEKEEPING	-2,480	852,319		9.00
10.00	01000	DIETARY	-39,198	592,178		10.00
11.00	01100	CAFETERIA	-422,897	380,802		11.00
13.00	01300	NURSING ADMINISTRATION	-2,824	444,020		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-950	-183,369		14.00
15.00	01500	PHARMACY	-176,089	641,761		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-17,718	562,324		16.00
20.00	02000	NURSING SCHOOL	-760,659	488,473		20.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-158,555	2,394,402		30.00
31.00	03100	INTENSIVE CARE UNIT	0	665,790		31.00
43.00	04300	NURSERY	0	266,518		43.00
44.00	04400	SKILLED NURSING FACILITY	7,345	948,365		44.00
45.00	04500	NURSING FACILITY	6,610	638,864		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-9,619	2,124,570		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	68,326		52.00
53.00	05300	ANESTHESIOLOGY	-1,171,310	67,996		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,302	1,344,916		54.00
57.00	05700	CT SCAN	-4,940	204,329		57.00
58.00	05800	MRI	0	178,029		58.00
60.00	06000	LABORATORY	-113,397	3,136,270		60.00
65.00	06500	RESPIRATORY THERAPY	-8,728	544,527		65.00
66.00	06600	PHYSICAL THERAPY	0	1,458,048		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,089,956		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,143,104		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,193,207		73.00
76.97	07697	CARDIAC REHABILITATION	-28,682	251,830		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-55,278	10,170,405		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	-29,169	388,689		90.01
91.00	09100	EMERGENCY	-2,187,636	1,159,855		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	-43,870	1,049,354		96.00
101.00	10100	HOME HEALTH AGENCY	-1,258	743,366		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
116.00	11600	HOSPICE	0	156,020		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-11,357,704	60,533,361		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,084,714		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	NONPAID WORKERS	0	0		193.01
193.02	19302	FOUNDATION	0	748		193.02
194.00	07950	PHYSICIANS CLINIC	0	0		194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0		194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0		194.02
194.03	07953	RUCHFORD POB	0	9,529		194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0		194.04
194.05	07955	FARMINGTON POB	0	0		194.05
194.06	07956	LEWISTON POB	0	0		194.06
194.07	07957	OTHER RENTAL PROPERTY	0	19,130		194.07
194.08	07958	KELLEY HOME	0	0		194.08
194.09	07959	EMPLOYEE PURCHASE	0	45,783		194.09
194.10	07960	RETAIL PHARMACY	0	0		194.10
200.00		TOTAL (SUM OF LINES 118-199)	-11,357,704	62,693,265		200.00

COST CENTERS USED IN COST REPORT | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet Non-CMS W | Date/Time Prepared: 11/20/2015 10:22 am

	Cost Center Description	CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	00101		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
3.00	OTHER CAP REL COSTS	00300		3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
20.00	NURSING SCHOOL	02000		20.00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
45.00	NURSING FACILITY	04500		45.00
	ANCILLARY SERVICE COST CENTERS			
50.00	OPERATING ROOM	05000		50.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
60.00	LABORATORY	06000		60.00
65.00	RESPIRATORY THERAPY	06500		65.00
66.00	PHYSICAL THERAPY	06600		66.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
76.97	CARDIAC REHABILITATION	07697	CARDIAC REHABILITATION	76.97
	OUTPATIENT SERVICE COST CENTERS			
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
90.01	WOUND CLINIC	09001		90.01
91.00	EMERGENCY	09100		91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
	OTHER REIMBURSABLE COST CENTERS			
96.00	DURABLE MEDICAL EQUIP-RENTED	09600		96.00
101.00	HOME HEALTH AGENCY	10100		101.00
	SPECIAL PURPOSE COST CENTERS			
113.00	INTEREST EXPENSE	11300		113.00
116.00	HOSPICE	11600		116.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
	NONREIMBURSABLE COST CENTERS			
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
193.00	NONPAID WORKERS	19300		193.00
193.01	NONPAID WORKERS	19301		193.01
193.02	FOUNDATION	19302		193.02
194.00	PHYSICIANS CLINIC	07950		194.00
194.01	PROCTOR CHEMICAL DEPENDENCY	07951		194.01
194.02	ST. FRANCIS RENAL DIALYSIS	07952		194.02
194.03	RUCHFORD POB	07953		194.03
194.04	EP COLEMAN RENTAL SPACE	07954		194.04
194.05	FARMINGTON POB	07955		194.05
194.06	LEWISTON POB	07956		194.06
194.07	OTHER RENTAL PROPERTY	07957		194.07
194.08	KELLEY HOME	07958		194.08
194.09	EMPLOYEE PURCHASE	07959		194.09
194.10	RETAIL PHARMACY	07960		194.10
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/20/2015 10:22 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	314,851	488,848	1.00
	TOTALS		314,851	488,848	
	B - MAINTENANCE LABOR RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,906	0	1.00
	TOTALS		1,906	0	
	C - OFFSITE CAPITAL RECLASS				
1.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	30,815	1.00
2.00	RUCHFORD POB	194.03	0	8,903	2.00
3.00	HOSPICE	116.00	0	4,956	3.00
4.00	HOME HEALTH AGENCY	101.00	0	4,956	4.00
	TOTALS		0	49,630	
	D - PROPERTY INSURANCE RECLASS				
1.00	OTHER CAP REL COSTS	3.00	0	69,034	1.00
2.00	RUCHFORD POB	194.03	0	626	2.00
	TOTALS		0	69,660	
	E - DEPRECIATION RECLASS				
1.00	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	25,187	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,147,926	2.00
	TOTALS		0	3,173,113	
	F - RHC EXPENSE RECLASS				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	176,788	1,860,542	1.00
	TOTALS		176,788	1,860,542	
	G - EXECUTIVE BENEFIT RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	129,412	1.00
	TOTALS		0	129,412	
	H - EMPLOYEE BENEFIT AUDIT RECLASS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19,000	1.00
	TOTALS		0	19,000	
	I - IMPLANT RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,143,104	1.00
	TOTALS		0	1,143,104	
	J - MED SUP CHARGE TO PATIENTS RECLASS				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,089,956	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	1,089,956	
	K - NURSING SCHOOL TUITION FORGIVENESS				
1.00	NURSING SCHOOL	20.00	0	38,895	1.00
	TOTALS		0	38,895	
500.00	Grand Total: Increases		493,545	8,062,160	500.00

RECLASSIFICATIONS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/20/2015 10:22 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - CAFETERIA RECLASS						
1.00	DIETARY	10.00	314,851	488,848	0		1.00
	TOTALS		314,851	488,848			
	B - MAINTENANCE LABOR RECLASS						
1.00	OPERATION OF PLANT	7.00	1,906	0	0		1.00
	TOTALS		1,906	0			
	C - OFFSITE CAPITAL RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	49,630	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	49,630			
	D - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	69,660	12		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	69,660			
	E - DEPRECIATION RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,173,113	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	3,173,113			
	F - RHC EXPENSE RECLASS						
1.00	RURAL HEALTH CLINIC	88.00	176,788	1,860,542	0		1.00
	TOTALS		176,788	1,860,542			
	G - EXECUTIVE BENEFIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	129,412	0		1.00
	TOTALS		0	129,412			
	H - EMPLOYEE BENEFIT AUDIT RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	19,000	0		1.00
	TOTALS		0	19,000			
	I - IMPLANT RECLASS						
1.00	OPERATING ROOM	50.00	0	1,143,104	0		1.00
	TOTALS		0	1,143,104			
	J - MED SUP CHARGE TO PATIENTS RECLASS						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	587,067	0		1.00
2.00	OPERATING ROOM	50.00	0	502,889	0		2.00
	TOTALS		0	1,089,956			
	K - NURSING SCHOOL TUITION FORGIVENESS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38,895	0		1.00
	TOTALS		0	38,895			
500.00	Grand Total: Decreases		493,545	8,062,160			500.00

RECLASSIFICATIONS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 Non-CMS Worksheet Date/Time Prepared: 11/20/2015 10:22 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
	A - CAFETERIA RECLASS								
1.00	CAFETERIA	11.00	314,851	488,848	DIETARY	10.00	314,851	488,848	1.00
	TOTALS		314,851	488,848	TOTALS		314,851	488,848	
	B - MAINTENANCE LABOR RECLASS								
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,906	0	OPERATION OF PLANT	7.00	1,906	0	1.00
	TOTALS		1,906	0	TOTALS		1,906	0	
	C - OFFSITE CAPITAL RECLASS								
1.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	30,815	CAP REL COSTS-BLDG & FIXT	1.00	0	49,630	1.00
2.00	RUCHFORD POB	194.03	0	8,903		0.00	0	0	2.00
3.00	HOSPICE	116.00	0	4,956		0.00	0	0	3.00
4.00	HOME HEALTH AGENCY	101.00	0	4,956		0.00	0	0	4.00
	TOTALS		0	49,630	TOTALS		0	49,630	
	D - PROPERTY INSURANCE RECLASS								
1.00	OTHER CAP REL COSTS	3.00	0	69,034	ADMINISTRATIVE & GENERAL	5.00	0	69,660	1.00
2.00	RUCHFORD POB	194.03	0	626		0.00	0	0	2.00
	TOTALS		0	69,660	TOTALS		0	69,660	
	E - DEPRECIATION RECLASS								
1.00	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	25,187	CAP REL COSTS-BLDG & FIXT	1.00	0	3,173,113	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,147,926		0.00	0	0	2.00
	TOTALS		0	3,173,113	TOTALS		0	3,173,113	
	F - RHC EXPENSE RECLASS								
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	176,788	1,860,542	RURAL HEALTH CLINIC	88.00	176,788	1,860,542	1.00
	TOTALS		176,788	1,860,542	TOTALS		176,788	1,860,542	
	G - EXECUTIVE BENEFIT RECLASS								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	129,412	ADMINISTRATIVE & GENERAL	5.00	0	129,412	1.00
	TOTALS		0	129,412	TOTALS		0	129,412	
	H - EMPLOYEE BENEFIT AUDIT RECLASS								
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19,000	ADMINISTRATIVE & GENERAL	5.00	0	19,000	1.00
	TOTALS		0	19,000	TOTALS		0	19,000	
	I - IMPLANT RECLASS								
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,143,104	OPERATING ROOM	50.00	0	1,143,104	1.00
	TOTALS		0	1,143,104	TOTALS		0	1,143,104	
	J - MED SUP CHARGE TO PATIENTS RECLASS								
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	1,089,956	CENTRAL SERVICES & SUPPLY	14.00	0	587,067	1.00
2.00		0.00	0	0	OPERATING ROOM	50.00	0	502,889	2.00
	TOTALS		0	1,089,956	TOTALS		0	1,089,956	
	K - NURSING SCHOOL TUITION FORGIVENESS								
1.00	NURSING SCHOOL	20.00	0	38,895	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38,895	1.00
	TOTALS		0	38,895	TOTALS		0	38,895	
500.00	Grand Total: Increases		493,545	8,062,160	Grand Total: Decreases		493,545	8,062,160	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 11/20/2015 10:22 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	4,642,457	408,078	0	408,078	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	64,596,219	0	0	0	221,747	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	14,817,649	0	0	0	2,990,245	5.00
6.00	Movable Equipment	29,764,327	0	0	0	1,105,406	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	113,820,652	408,078	0	408,078	4,317,398	8.00
9.00	Reconciling Items	-123,466	-383,173	0	-383,173	0	9.00
10.00	Total (line 8 minus line 9)	113,944,118	791,251	0	791,251	4,317,398	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	5,050,535	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	64,374,472	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	11,827,404	0	5.00
6.00	Movable Equipment	28,658,921	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	109,911,332	0	8.00
9.00	Reconciling Items	-506,639	0	9.00
10.00	Total (line 8 minus line 9)	110,417,971	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 11/20/2015 10:22 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	6,868,693	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	6,868,693	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	6,868,693		1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	6,868,693		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 11/20/2015 10:22 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	80,745,772	0	80,745,772	0.734644	50,716	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	506,639	0	506,639	0.004610	318	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	28,658,921	0	28,658,921	0.260746	18,000	2.00
3.00	Total (sum of lines 1-2)	109,911,332	0	109,911,332	1.000000	69,034	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	50,716	3,645,950	0	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	0	318	25,187	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	18,000	3,147,399	0	2.00
3.00	Total (sum of lines 1-2)	0	0	69,034	6,818,536	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-920,071	50,716	0	0	2,776,595	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	0	318	0	0	25,505	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	18,000	0	0	3,165,399	2.00
3.00	Total (sum of lines 1-2)	-920,071	69,034	0	0	5,967,499	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/20/2015 10:22 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
1.01	Investment income - NEW CAP REL COSTS-CARDIAC REHAB (chapter 2)		0	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	1.01
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	-2,478,271			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	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-CARDIAC REHAB		0	NEW CAP REL COSTS-CARDIAC REHAB	1.01	0	26.01
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	*** Cost Center Deleted ***	67.00		30.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/20/2015 10:22 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	
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	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	INVST INCOME-NEW BLDGS AND FIXTURES	B	-78,294	CAP REL COSTS-BLDG & FIXT	1.00	11	33.00
33.01			0		0.00	0	33.01
33.02	TRADE, QUANTITY AND TIME DISCOUNTS	B	-13,860	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	OTHER REVE EMPLOYEE REIMBURSEMENTS	B	-2	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	MEDICAL STAFF DUES	B	-14,425	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	OTHER INCOME & PURCHASE GROUP	B	-158,308	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06			0		0.00	0	33.06
33.07	HOUSKEEPING OTHER REVENUE	B	-2,480	HOUSEKEEPING	9.00	0	33.07
33.08	DIETARY CONSULTANT AND EMP PURCHASE	B	-33,765	DIETARY	10.00	0	33.08
33.09	REFUND/EXP REBATE	B	-4,993	DIETARY	10.00	0	33.09
33.10	CAFETERIA--EMPLOYEES AND GUESTS	B	-422,897	CAFETERIA	11.00	0	33.10
33.11	NRSG SVS CPR CLASS FEES	B	-2,824	NURSING ADMINISTRATION	13.00	0	33.11
33.12			0		0.00	0	33.12
33.13			0		0.00	0	33.13
33.14	SALE OF DRUGS TO OTHER THAN PATIENTS	B	-173,857	PHARMACY	15.00	0	33.14
33.15	REFUND/EXP REBATE	B	-2,232	PHARMACY	15.00	0	33.15
33.16	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-17,718	MEDICAL RECORDS & LIBRARY	16.00	0	33.16
33.17			0		0.00	0	33.17
33.18	LAMAZE CLASS FEES	B	-609	ADULTS & PEDIATRICS	30.00	0	33.18
33.19			0		0.00	0	33.19
33.20	MISCELLANEOUS INCOME	B	-20	RADIOLOGY-DIAGNOSTIC	54.00	0	33.20
33.21	CT SCAN OTHER REVENUE	B	-4,940	CT SCAN	57.00	0	33.21
33.22	MISCELLANEOUS LAB REVENUE	B	-2,375	LABORATORY	60.00	0	33.22
33.23			0		0.00	0	33.23
33.24			0		0.00	0	33.24
33.25	CARDIAC OTHER REVENUE	B	-28,682	CARDIAC REHABILITATION	76.97	0	33.25
33.26	RHC OTHER INCOME	B	-55,278	RURAL HEALTH CLINIC	88.00	0	33.26
33.27	HME NON PATIENT SALES	B	-24,010	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.27
33.28	HME HME OTHER REVENUE	B	-19,860	DURABLE MEDICAL EQUIP-RENTED	96.00	0	33.28
33.29			0		0.00	0	33.29
33.30	GRI RESPIRATOR OTHER REVENUE	B	-8,728	RESPIRATORY THERAPY	65.00	0	33.30
33.31	GRI SURGERY VENDOR REBATES/REFUNDS	B	-349	OPERATING ROOM	50.00	0	33.31
33.32	GRI CENT SUPP VENDOR REBATES/REFUNDS	B	-950	CENTRAL SERVICES & SUPPLY	14.00	0	33.32
33.33	GRI LABORATORY VENDOR REBATES/REFUND	B	-8,102	LABORATORY	60.00	0	33.33
33.34	GRI IMAGING VENDOR REBATES/REFUNDS	B	-682	RADIOLOGY-DIAGNOSTIC	54.00	0	33.34
33.35	GRI FOOD/NUTRI GUEST MEAL VOUCHERS	B	-440	DIETARY	10.00	0	33.35
33.36	GRI BIO MED TE OTHER REVENUE	B	-400	OPERATION OF PLANT	7.00	0	33.36
33.37	GRI PT ACCESS OTHER REVENUE	B	-1,064	ADMINISTRATIVE & GENERAL	5.00	0	33.37
33.38	GRI MARKETING OTHER REVENUE	B	5	ADMINISTRATIVE & GENERAL	5.00	0	33.38
33.39	GRI QUALITY OTHER REVENUE	B	-2,000	ADMINISTRATIVE & GENERAL	5.00	0	33.39
33.40	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)	B	-760,659	NURSING SCHOOL	20.00	0	33.40
33.41	DONATIONS & DUES	A	-11,594	ADMINISTRATIVE & GENERAL	5.00	0	33.41
33.42	CRNA SALARY EXPENSE	A	-1,171,310	ANESTHESIOLOGY	53.00	0	33.42
33.43	CRNA BENEFIT EXPENSE	A	-33,630	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.43
33.44			0		0.00	0	33.44
33.45			0		0.00	0	33.45
33.46	IL PROVIDER PARTICIPATION FEE	A	7,345	SKILLED NURSING FACILITY	44.00	0	33.46

ADJUSTMENTS TO EXPENSES | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/20/2015 10:22 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.47	IL PROVIDER PARTICIPATION FEE	A	6,610	NURSING FACILITY	45.00	0	33.47
33.48	IL HOSPITAL PROVIDER TAX	A	-1,808,059	ADMINISTRATIVE & GENERAL	5.00	0	33.48
33.49			0		0.00	0	33.49
33.50	PHONE SALARIES EXPENSE	A	-5,481	ADMINISTRATIVE & GENERAL	5.00	0	33.50
33.51	PHONE BENEFIT EXPENSE	A	-868	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.51
33.52			0		0.00	0	33.52
33.53	PHONE DEPREPATION M/M EXPENSE	A	-527	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.53
33.54	IHA & AHA DUES LOBBYING PORTION	A	-31,748	ADMINISTRATIVE & GENERAL	5.00	0	33.54
33.55			0		0.00	0	33.55
33.56	IL HOMECARE COUNCIL LOBBYING	A	-1,258	HOME HEALTH AGENCY	101.00	0	33.56
33.57	MARKETING DEPT SALARY EXPENSE	A	-112,737	ADMINISTRATIVE & GENERAL	5.00	0	33.57
33.58	MARKETING DEPT BENEIFT EXPENSE	A	-12,780	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.58
33.59	MARKETING DEPT OTHER EXPENSE	A	-211,030	ADMINISTRATIVE & GENERAL	5.00	0	33.59
33.60			0		0.00	0	33.60
33.61	PHYSICIAN RECRUITMENT	A	-178,440	ADMINISTRATIVE & GENERAL	5.00	0	33.61
33.62	LOAN FORGIVENESS EXPENSE	A	-123,242	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.62
33.63	ER PHYSICIAN BENEFITS	A	-38,543	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.63
33.64	SELF INSURANCE COSTS	A	-2,456,296	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.64
33.65	SWAP INTEREST RATE EXPENSE	A	-841,777	CAP REL COSTS-BLDG & FIXT	1.00	11	33.65
33.66	GRI SURGERY OTHER REVENUE	B	-9,270	OPERATING ROOM	50.00	0	33.66
33.67			0		0.00	0	33.67
33.68			0		0.00	0	33.68
33.69			0		0.00	0	33.69
33.70			0		0.00	0	33.70
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-11,357,704				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: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 11/20/2015 10:22 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	91.00	EMERGENCY	2,127,743	2,105,827	21,916	159,800	86	1.00
2.00	91.00	EMERGENCY	66,500	66,500	0	0	0	2.00
3.00	60.00	LABORATORY	52,250	52,250	0	0	0	3.00
4.00	60.00	LABORATORY	50,670	50,670	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	600	600	0	0	0	6.00
7.00	90.01	WOUND CLINIC	29,169	29,169	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	157,946	157,946	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,484,878	2,462,962	21,916		86	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	91.00	EMERGENCY	6,607	330	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	6.00
7.00	90.01	WOUND CLINIC	0	0	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			6,607	330	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	6,607	15,309	2,121,136		1.00
2.00	91.00	EMERGENCY	0	0	0	66,500		2.00
3.00	60.00	LABORATORY	0	0	0	52,250		3.00
4.00	60.00	LABORATORY	0	0	0	50,670		4.00
5.00	0.00		0	0	0	0		5.00
6.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	600		6.00
7.00	90.01	WOUND CLINIC	0	0	0	29,169		7.00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	157,946		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	6,607	15,309	2,478,271		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,776,595	2,776,595				1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	25,505	0	25,505			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,165,399			3,165,399		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,779,992	17,822	0	894	5,798,708	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,727,945	295,692	0	1,419,725	1,249,776	5.00
7.00	00700	OPERATION OF PLANT	2,623,276	322,056	0	46,405	187,751	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	269,405	32,471	0	1,797	5,954	8.00
9.00	00900	HOUSEKEEPING	852,319	30,548	0	7,902	164,388	9.00
10.00	01000	DIETARY	592,178	83,838	0	23,550	57,646	10.00
11.00	01100	CAFETERIA	380,802	22,414	0	0	73,379	11.00
13.00	01300	NURSING ADMINISTRATION	444,020	25,587	0	2,131	99,855	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-183,369	0	0	1,816	12,660	14.00
15.00	01500	PHARMACY	641,761	19,160	0	81,917	166,510	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	562,324	71,497	0	5,167	104,246	16.00
20.00	02000	NURSING SCHOOL	488,473	250,327	0	40,683	237,720	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,394,402	172,708	0	125,441	569,585	30.00
31.00	03100	INTENSIVE CARE UNIT	665,790	30,131	0	11,957	145,102	31.00
43.00	04300	NURSERY	266,518	8,735	0	5,378	60,622	43.00
44.00	04400	SKILLED NURSING FACILITY	948,365	73,132	0	5,407	199,732	44.00
45.00	04500	NURSING FACILITY	638,864	52,713	0	6,018	143,787	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,124,570	169,847	0	489,330	338,593	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	68,326	25,892	0	0	15,924	52.00
53.00	05300	ANESTHESIOLOGY	67,996	10,193	0	25,855	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,344,916	88,397	0	284,636	187,466	54.00
57.00	05700	CT SCAN	204,329	0	0	156,855	12,244	57.00
58.00	05800	MRI	178,029	23,993	0	127,908	12,209	58.00
60.00	06000	LABORATORY	3,136,270	129,924	0	91,554	350,621	60.00
65.00	06500	RESPIRATORY THERAPY	544,527	1,571	0	22,353	111,161	65.00
66.00	06600	PHYSICAL THERAPY	1,458,048	50,101	0	3,524	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,089,956	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,143,104	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,193,207	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	251,830	0	25,505	9,567	55,180	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,170,405	392,900	0	83,180	713,493	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	388,689	26,813	0	0	0	90.01
91.00	09100	EMERGENCY	1,159,855	105,699	0	55,248	240,940	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,049,354	0	0	20,679	90,410	96.00
101.00	10100	HOME HEALTH AGENCY	743,366	0	0	6,255	111,841	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	156,020	0	0	0	29,035	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	60,533,361	2,534,161	25,505	3,163,132	5,747,830	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,744	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,084,714	114,634	0	2,267	50,878	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	748	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	22,262	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	48,081	0	0	0	194.02
194.03	07953	RUCHFORD POB	9,529	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	47,713	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	19,130	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	45,783	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/20/2015 10:22 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP		
		0	1.00	1.01	2.00	4.00	
202.00	TOTAL (sum lines 118-201)	62,693,265	2,776,595	25,505	3,165,399	5,798,708	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,693,138	12,693,138				5.00
7.00	00700	OPERATION OF PLANT	3,179,488	804,433	3,983,921			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	309,627	78,338	60,420	448,385		8.00
9.00	00900	HOUSEKEEPING	1,055,157	266,962	56,842	9,764	1,388,725	9.00
10.00	01000	DIETARY	757,212	191,580	156,001	0	39,010	10.00
11.00	01100	CAFETERIA	476,595	120,582	41,707	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	571,593	144,617	47,612	0	14,790	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-168,893	0	0	0	0	14.00
15.00	01500	PHARMACY	909,348	230,071	35,653	0	14,833	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	743,234	188,043	133,038	0	9,260	16.00
20.00	02000	NURSING SCHOOL	1,017,203	257,359	465,797	89	18,562	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,262,136	825,343	321,367	156,596	392,761	30.00
31.00	03100	INTENSIVE CARE UNIT	852,980	215,810	56,066	17,193	45,012	31.00
43.00	04300	NURSERY	341,253	86,339	16,253	3,256	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,226,636	310,347	136,080	54,802	101,984	44.00
45.00	04500	NURSING FACILITY	841,382	212,876	98,086	49,484	101,427	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,122,340	789,974	316,043	73,819	249,880	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	110,142	27,867	48,178	0	0	52.00
53.00	05300	ANESTHESIOLOGY	104,044	26,324	18,967	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,905,415	482,083	164,486	20,469	50,885	54.00
57.00	05700	CT SCAN	373,428	94,480	0	0	0	57.00
58.00	05800	MRI	342,139	86,564	44,644	3,878	0	58.00
60.00	06000	LABORATORY	3,708,369	938,243	241,756	67	39,996	60.00
65.00	06500	RESPIRATORY THERAPY	679,612	171,947	2,923	156	10,889	65.00
66.00	06600	PHYSICAL THERAPY	1,511,673	382,464	93,225	9,672	27,736	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,089,956	275,766	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,143,104	289,213	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,193,207	554,897	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	342,082	86,549	0	0	31,208	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,359,978	2,874,181	731,097	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	415,502	105,125	49,893	0	0	90.01
91.00	09100	EMERGENCY	1,561,742	395,132	196,679	47,391	156,041	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,160,443	293,600	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	861,462	217,956	0	0	4,758	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	185,055	46,820	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	60,237,782	12,071,885	3,532,813	446,636	1,309,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,744	2,465	18,132	0	7,974	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,252,493	569,896	213,305	1,749	71,719	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	748	189	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	22,262	5,632	41,423	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	48,081	12,165	89,467	0	0	194.02
194.03	07953	RUCHFORD POB	9,529	2,411	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	47,713	12,072	88,781	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	19,130	4,840	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	45,783	11,583	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
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)	62,693,265	12,693,138	3,983,921	448,385	1,388,725	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,143,803					10.00
11.00	01100	CAFETERIA	0	638,884				11.00
13.00	01300	NURSING ADMINISTRATION	0	14,529	793,141			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,636	0	-164,257		14.00
15.00	01500	PHARMACY	0	28,048	0	0	1,217,953	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46,479	0	0	0	16.00
20.00	02000	NURSING SCHOOL	0	38,147	0	0	187	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	468,327	107,764	270,546	0	1,055	30.00
31.00	03100	INTENSIVE CARE UNIT	59,127	21,254	53,360	0	211	31.00
43.00	04300	NURSERY	0	7,115	17,864	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	279,988	43,128	108,276	0	174	44.00
45.00	04500	NURSING FACILITY	336,361	39,570	99,344	0	39	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	58,850	147,749	0	4,988	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,397	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	11,476	28,812	0	479	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	34,727	0	0	2,828	54.00
57.00	05700	CT SCAN	0	2,066	0	0	76	57.00
58.00	05800	MRI	0	2,135	0	0	0	58.00
60.00	06000	LABORATORY	0	95,161	0	0	350	60.00
65.00	06500	RESPIRATORY THERAPY	0	15,814	0	0	1,202	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	55	66.00
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	885,382	73.00
76.97	07697	CARDIAC REHABILITATION	0	9,938	0	0	193	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	309,300	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	493	90.01
91.00	09100	EMERGENCY	0	54,650	0	0	855	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	4,840	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	52,265	0	69	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	14,925	0	4,791	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,143,803	638,884	793,141	0	1,217,567	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	386	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	-164,257	0	201.00
202.00		TOTAL (sum lines 118-201)	1,143,803	638,884	793,141	-164,257	1,217,953	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	20.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	1,120,054					16.00
20.00	02000	NURSING SCHOOL	0	1,797,344				20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	254,974	840,772	6,901,641	0	6,901,641	30.00
31.00	03100	INTENSIVE CARE UNIT	22,646	108,031	1,451,690	0	1,451,690	31.00
43.00	04300	NURSERY	11,700	0	483,780	0	483,780	43.00
44.00	04400	SKILLED NURSING FACILITY	11,318	295,945	2,568,678	0	2,568,678	44.00
45.00	04500	NURSING FACILITY	14,211	19,140	1,811,920	0	1,811,920	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	156,637	190,954	5,111,234	0	5,111,234	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	189,584	0	189,584	52.00
53.00	05300	ANESTHESIOLOGY	0	0	190,102	0	190,102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	305,585	18,015	2,984,493	0	2,984,493	54.00
57.00	05700	CT SCAN	0	0	470,050	0	470,050	57.00
58.00	05800	MRI	0	0	479,360	0	479,360	58.00
60.00	06000	LABORATORY	123,940	0	5,147,882	0	5,147,882	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	882,543	0	882,543	65.00
66.00	06600	PHYSICAL THERAPY	0	13,511	2,038,336	0	2,038,336	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,365,722	0	1,365,722	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,432,317	0	1,432,317	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,385	3,645,871	0	3,645,871	73.00
76.97	07697	CARDIAC REHABILITATION	0	29,274	499,244	0	499,244	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	98,179	15,372,735	0	15,372,735	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	1,801	572,814	0	572,814	90.01
91.00	09100	EMERGENCY	219,043	65,303	2,696,836	0	2,696,836	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	1,458,883	0	1,458,883	96.00
101.00	10100	HOME HEALTH AGENCY	0	74,310	1,210,820	0	1,210,820	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	29,724	281,315	0	281,315	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,120,054	1,797,344	59,247,850	0	59,247,850	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	38,315	0	38,315	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	3,109,548	0	3,109,548	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	937	0	937	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	69,317	0	69,317	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0	149,713	0	149,713	194.02
194.03	07953	RUCHFORD POB	0	0	11,940	0	11,940	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	148,566	0	148,566	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	23,970	0	23,970	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	57,366	0	57,366	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	-164,257	0	-164,257	201.00
202.00		TOTAL (sum lines 118-201)	1,120,054	1,797,344	62,693,265	0	62,693,265	202.00

COST ALLOCATION STATISTICS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet Non-CMS W | Date/Time Prepared: 11/20/2015 10:22 am

	Cost Center Description	Statistics Code	Statistics Description	
		1.00	2.00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
1.01	NEW CAP REL COSTS-CARDIAC REHAB	2	SQUARE FEET	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	3	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	5	GROSS SALA RIE	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	6	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	7	HOURS OF SERVICE	9.00
10.00	DIETARY	8	MEALS SERVED	10.00
11.00	CAFETERIA	9	FTES	11.00
13.00	NURSING ADMINISTRATION	10	FTES	13.00
14.00	CENTRAL SERVICES & SUPPLY	11	COSTED REQUIS.	14.00
15.00	PHARMACY	12	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	13	TIME SPENT	16.00
20.00	NURSING SCHOOL	14	ASSIGNED TIME	20.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS NEW CARDIAC REHAB	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	17,822	0	894	18,716	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	295,692	0	1,419,725	1,715,417	5.00
7.00	00700	OPERATION OF PLANT	0	322,056	0	46,405	368,461	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	32,471	0	1,797	34,268	8.00
9.00	00900	HOUSEKEEPING	0	30,548	0	7,902	38,450	9.00
10.00	01000	DIETARY	0	83,838	0	23,550	107,388	10.00
11.00	01100	CAFETERIA	0	22,414	0	0	22,414	11.00
13.00	01300	NURSING ADMINISTRATION	0	25,587	0	2,131	27,718	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	1,816	1,816	14.00
15.00	01500	PHARMACY	0	19,160	0	81,917	101,077	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	71,497	0	5,167	76,664	16.00
20.00	02000	NURSING SCHOOL	0	250,327	0	40,683	291,010	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	172,708	0	125,441	298,149	30.00
31.00	03100	INTENSIVE CARE UNIT	0	30,131	0	11,957	42,088	31.00
43.00	04300	NURSERY	0	8,735	0	5,378	14,113	43.00
44.00	04400	SKILLED NURSING FACILITY	0	73,132	0	5,407	78,539	44.00
45.00	04500	NURSING FACILITY	0	52,713	0	6,018	58,731	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	169,847	0	489,330	659,177	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	25,892	0	0	25,892	52.00
53.00	05300	ANESTHESIOLOGY	0	10,193	0	25,855	36,048	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	88,397	0	284,636	373,033	54.00
57.00	05700	CT SCAN	0	0	0	156,855	156,855	57.00
58.00	05800	MRI	0	23,993	0	127,908	151,901	58.00
60.00	06000	LABORATORY	0	129,924	0	91,554	221,478	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,571	0	22,353	23,924	65.00
66.00	06600	PHYSICAL THERAPY	0	50,101	0	3,524	53,625	66.00
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
76.97	07697	CARDIAC REHABILITATION	0	0	25,505	9,567	35,072	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	392,900	0	83,180	476,080	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	26,813	0	0	26,813	90.01
91.00	09100	EMERGENCY	0	105,699	0	55,248	160,947	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	20,679	20,679	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	0	6,255	6,255	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,534,161	25,505	3,163,132	5,722,798	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9,744	0	0	9,744	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	114,634	0	2,267	116,901	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	22,262	0	0	22,262	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	48,081	0	0	48,081	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	47,713	0	0	47,713	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
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	2,776,595	25,505	3,165,399	5,967,499	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			4.00	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	18,716					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,039	1,719,456				5.00
7.00	00700	OPERATION OF PLANT	606	108,971	478,038			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19	10,612	7,250	52,149		8.00
9.00	00900	HOUSEKEEPING	530	36,163	6,821	1,136	83,100	9.00
10.00	01000	DIETARY	186	25,952	18,719	0	2,334	10.00
11.00	01100	CAFETERIA	237	16,334	5,004	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	322	19,590	5,713	0	885	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	41	0	0	0	0	14.00
15.00	01500	PHARMACY	537	31,166	4,278	0	888	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	336	25,473	15,963	0	554	16.00
20.00	02000	NURSING SCHOOL	767	34,863	55,892	10	1,111	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,838	111,803	38,561	18,212	23,502	30.00
31.00	03100	INTENSIVE CARE UNIT	468	29,234	6,727	2,000	2,693	31.00
43.00	04300	NURSERY	196	11,696	1,950	379	0	43.00
44.00	04400	SKILLED NURSING FACILITY	644	42,040	16,328	6,374	6,103	44.00
45.00	04500	NURSING FACILITY	464	28,837	11,770	5,755	6,069	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,093	107,012	37,923	8,585	14,953	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	51	3,775	5,781	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,566	2,276	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	605	65,304	19,737	2,381	3,045	54.00
57.00	05700	CT SCAN	40	12,798	0	0	0	57.00
58.00	05800	MRI	39	11,726	5,357	451	0	58.00
60.00	06000	LABORATORY	1,131	127,097	29,009	8	2,393	60.00
65.00	06500	RESPIRATORY THERAPY	359	23,292	351	18	652	65.00
66.00	06600	PHYSICAL THERAPY	0	51,810	11,186	1,125	1,660	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	37,356	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	39,178	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	75,168	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	178	11,724	0	0	1,867	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,302	389,352	87,726	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	14,241	5,987	0	0	90.01
91.00	09100	EMERGENCY	777	53,526	23,600	5,512	9,337	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	292	39,772	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	361	29,525	0	0	285	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	94	6,342	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	18,552	1,635,298	423,909	51,946	78,331	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	334	2,176	0	477	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	164	77,200	25,595	203	4,292	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	26	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	763	4,970	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	1,648	10,735	0	0	194.02
194.03	07953	RUCHFORD POB	0	327	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	1,635	10,653	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	656	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	1,569	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
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)	18,716	1,719,456	478,038	52,149	83,100	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	154,579					10.00
11.00	01100	CAFETERIA	0	43,989				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,000	55,228			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	319	0	2,176		14.00
15.00	01500	PHARMACY	0	1,931	0	0	139,877	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,200	0	0	0	16.00
20.00	02000	NURSING SCHOOL	0	2,627	0	0	21	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	63,292	7,421	18,839	0	121	30.00
31.00	03100	INTENSIVE CARE UNIT	7,991	1,463	3,716	0	24	31.00
43.00	04300	NURSERY	0	490	1,244	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	37,839	2,969	7,539	0	20	44.00
45.00	04500	NURSING FACILITY	45,457	2,725	6,918	0	5	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,052	10,288	0	573	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	234	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	790	2,006	0	55	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,391	0	0	325	54.00
57.00	05700	CT SCAN	0	142	0	0	9	57.00
58.00	05800	MRI	0	147	0	0	0	58.00
60.00	06000	LABORATORY	0	6,552	0	0	40	60.00
65.00	06500	RESPIRATORY THERAPY	0	1,089	0	0	138	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	6	66.00
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	101,683	73.00
76.97	07697	CARDIAC REHABILITATION	0	684	0	0	22	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	35,522	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	0	0	57	90.01
91.00	09100	EMERGENCY	0	3,763	0	0	98	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	556	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	3,639	0	8	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	1,039	0	550	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	154,579	43,989	55,228	0	139,833	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	44	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	2,176	0	201.00
202.00		TOTAL (sum lines 118-201)	154,579	43,989	55,228	2,176	139,877	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			16.00	20.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	122,190					16.00
20.00	02000	NURSING SCHOOL	0	386,301				20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,816		609,554	0	609,554	30.00
31.00	03100	INTENSIVE CARE UNIT	2,470		98,874	0	98,874	31.00
43.00	04300	NURSERY	1,276		31,344	0	31,344	43.00
44.00	04400	SKILLED NURSING FACILITY	1,235		199,630	0	199,630	44.00
45.00	04500	NURSING FACILITY	1,550		168,281	0	168,281	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	17,088		860,744	0	860,744	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		35,733	0	35,733	52.00
53.00	05300	ANESTHESIOLOGY	0		44,741	0	44,741	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	33,338		500,159	0	500,159	54.00
57.00	05700	CT SCAN	0		169,844	0	169,844	57.00
58.00	05800	MRI	0		169,621	0	169,621	58.00
60.00	06000	LABORATORY	13,521		401,229	0	401,229	60.00
65.00	06500	RESPIRATORY THERAPY	0		49,823	0	49,823	65.00
66.00	06600	PHYSICAL THERAPY	0		119,412	0	119,412	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		37,356	0	37,356	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		39,178	0	39,178	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		176,851	0	176,851	73.00
76.97	07697	CARDIAC REHABILITATION	0		49,547	0	49,547	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		990,982	0	990,982	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	0		47,098	0	47,098	90.01
91.00	09100	EMERGENCY	23,896		281,456	0	281,456	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		61,299	0	61,299	96.00
101.00	10100	HOME HEALTH AGENCY	0		40,073	0	40,073	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0		8,025	0	8,025	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	122,190	0	5,190,854	0	5,190,854	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		12,731	0	12,731	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		224,399	0	224,399	192.00
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
193.01	19301	NONPAID WORKERS	0		0	0	0	193.01
193.02	19302	FOUNDATION	0		26	0	26	193.02
194.00	07950	PHYSICIANS CLINIC	0		27,995	0	27,995	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0		0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0		60,464	0	60,464	194.02
194.03	07953	RUCHFORD POB	0		327	0	327	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0		60,001	0	60,001	194.04
194.05	07955	FARMINGTON POB	0		0	0	0	194.05
194.06	07956	LEWISTON POB	0		0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0		656	0	656	194.07
194.08	07958	KELLEY HOME	0		0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0		1,569	0	1,569	194.09
194.10	07960	RETAIL PHARMACY	0		0	0	0	194.10
200.00		Cross Foot Adjustments		386,301	386,301	0	386,301	200.00
201.00		Negative Cost Centers	0	0	2,176	0	2,176	201.00
202.00		TOTAL (sum lines 118-201)	122,190	386,301	5,967,499	0	5,967,499	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	346,488					1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB	0	30,653				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			3,147,928			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,224	0	889	24,880,698		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,899	0	1,411,891	5,362,485	-12,693,138	5.00
7.00	00700	OPERATION OF PLANT	40,189	0	46,149	805,588	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,052	0	1,787	25,548	0	8.00
9.00	00900	HOUSEKEEPING	3,812	0	7,858	705,343	0	9.00
10.00	01000	DIETARY	10,462	0	23,420	247,343	0	10.00
11.00	01100	CAFETERIA	2,797	0	0	314,851	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,193	0	2,119	428,448	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,806	54,319	168,893	14.00
15.00	01500	PHARMACY	2,391	0	81,465	714,449	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,922	0	5,138	447,292	0	16.00
20.00	02000	NURSING SCHOOL	31,238	0	40,458	1,019,991	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	21,552	0	124,749	2,443,930	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,760	0	11,891	622,593	0	31.00
43.00	04300	NURSERY	1,090	0	5,348	260,114	0	43.00
44.00	04400	SKILLED NURSING FACILITY	9,126	0	5,377	856,996	0	44.00
45.00	04500	NURSING FACILITY	6,578	0	5,985	616,949	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,195	0	486,629	1,452,810	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,231	0	0	68,326	0	52.00
53.00	05300	ANESTHESIOLOGY	1,272	0	25,712	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,031	0	283,065	804,366	0	54.00
57.00	05700	CT SCAN	0	0	155,989	52,537	0	57.00
58.00	05800	MRI	2,994	0	127,202	52,387	0	58.00
60.00	06000	LABORATORY	16,213	0	91,049	1,504,418	0	60.00
65.00	06500	RESPIRATORY THERAPY	196	0	22,230	476,959	0	65.00
66.00	06600	PHYSICAL THERAPY	6,252	0	3,505	0	0	66.00
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
76.97	07697	CARDIAC REHABILITATION	0	30,653	9,514	236,764	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	49,030	0	82,721	3,061,400	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	3,346	0	0	0	0	90.01
91.00	09100	EMERGENCY	13,190	0	54,943	1,033,807	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	20,565	387,923	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	0	6,220	479,877	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	124,583	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	316,235	30,653	3,145,674	24,662,396	-12,524,245	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,216	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	14,305	0	2,254	218,302	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	2,778	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	6,000	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	5,954	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	
			1.00	1.01	2.00	4.00	5A	
202.00		Cost to be allocated (per Wkst. B, Part I)	2,776,595	25,505	3,165,399	5,798,708		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	8.013539	0.832056	1.005550	0.233061		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				18,716		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000752		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	50,169,020					5.00
7.00	00700	OPERATION OF PLANT	3,179,488	267,176				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	309,627	4,052	1,046,263			8.00
9.00	00900	HOUSEKEEPING	1,055,157	3,812	22,784	32,395		9.00
10.00	01000	DIETARY	757,212	10,462	0	910	58,557	10.00
11.00	01100	CAFETERIA	476,595	2,797	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	571,593	3,193	0	345	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	909,348	2,391	0	346	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	743,234	8,922	0	216	0	16.00
20.00	02000	NURSING SCHOOL	1,017,203	31,238	208	433	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,262,136	21,552	365,401	9,162	23,976	30.00
31.00	03100	INTENSIVE CARE UNIT	852,980	3,760	40,118	1,050	3,027	31.00
43.00	04300	NURSERY	341,253	1,090	7,597	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,226,636	9,126	127,876	2,379	14,334	44.00
45.00	04500	NURSING FACILITY	841,382	6,578	115,466	2,366	17,220	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,122,340	21,195	172,250	5,829	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	110,142	3,231	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	104,044	1,272	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,905,415	11,031	47,762	1,187	0	54.00
57.00	05700	CT SCAN	373,428	0	0	0	0	57.00
58.00	05800	MRI	342,139	2,994	9,048	0	0	58.00
60.00	06000	LABORATORY	3,708,369	16,213	156	933	0	60.00
65.00	06500	RESPIRATORY THERAPY	679,612	196	364	254	0	65.00
66.00	06600	PHYSICAL THERAPY	1,511,673	6,252	22,568	647	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,089,956	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,143,104	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,193,207	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	342,082	0	0	728	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	11,359,978	49,030	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	415,502	3,346	0	0	0	90.01
91.00	09100	EMERGENCY	1,561,742	13,190	110,583	3,640	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,160,443	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	861,462	0	0	111	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	185,055	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	47,713,537	236,923	1,042,181	30,536	58,557	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9,744	1,216	0	186	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,252,493	14,305	4,082	1,673	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	748	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	22,262	2,778	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	48,081	6,000	0	0	0	194.02
194.03	07953	RUCHFORD POB	9,529	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	47,713	5,954	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	19,130	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	45,783	0	0	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
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)	12,693,138	3,983,921	448,385	1,388,725	1,143,803	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.253007	14.911223	0.428559	42.868498	19.533156	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			5.00	7.00	8.00	9.00	10.00	
204.00		Cost to be allocated (per Wkst. B, Part II)	1,719,456	478,038	52,149	83,100	154,579	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.034273	1.789225	0.049843	2.565211	2.639804	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
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	27,835					11.00
13.00	01300	NURSING ADMINISTRATION	633	13,764				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	202	0	2,998,558			14.00
15.00	01500	PHARMACY	1,222	0	16,989	2,792,730		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,025	0	0	0	105,300	16.00
20.00	02000	NURSING SCHOOL	1,662	0	2,816	429	0	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,695	4,695	39,556	2,419	23,971	30.00
31.00	03100	INTENSIVE CARE UNIT	926	926	7,524	483	2,129	31.00
43.00	04300	NURSERY	310	310	4,847	0	1,100	43.00
44.00	04400	SKILLED NURSING FACILITY	1,879	1,879	11,139	399	1,064	44.00
45.00	04500	NURSING FACILITY	1,724	1,724	5,217	90	1,336	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,564	2,564	339,572	11,437	14,726	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	148	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	500	500	5,306	1,098	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,513	0	8,913	6,485	28,729	54.00
57.00	05700	CT SCAN	90	0	5,329	174	0	57.00
58.00	05800	MRI	93	0	163	0	0	58.00
60.00	06000	LABORATORY	4,146	0	45,144	802	11,652	60.00
65.00	06500	RESPIRATORY THERAPY	689	0	6,886	2,757	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	4,678	125	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,090,649	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,143,104	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,030,159	0	73.00
76.97	07697	CARDIAC REHABILITATION	433	0	3,084	442	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	152,100	709,215	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	0	41,174	1,131	0	90.01
91.00	09100	EMERGENCY	2,381	0	27,898	1,960	20,593	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	11,097	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	907	20,095	159	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	259	0	10,985	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,835	13,764	2,982,183	2,791,846	105,300	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	484	884	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	NONPAID WORKERS	0	0	0	0	0	193.01
193.02	19302	FOUNDATION	0	0	0	0	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	0	0	0	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	0	0	0	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	0	0	0	0	194.02
194.03	07953	RUCHFORD POB	0	0	0	0	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	0	0	0	0	194.04
194.05	07955	FARMINGTON POB	0	0	0	0	0	194.05
194.06	07956	LEWISTON POB	0	0	0	0	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	0	0	0	0	194.07
194.08	07958	KELLEY HOME	0	0	0	0	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	0	15,891	0	0	194.09
194.10	07960	RETAIL PHARMACY	0	0	0	0	0	194.10
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)	638,884	793,141	-164,257	1,217,953	1,120,054	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
			11.00	13.00	14.00	15.00	16.00	
203.00		Unit cost multiplier (Wkst. B, Part I)	22.952542	57.624310	0.000000	0.436116	10.636790	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	43,989	55,228	2,176	139,877	122,190	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.580348	4.012496	0.000726	0.050086	1.160399	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)	
			20.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-CARDIAC REHAB		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
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
20.00	02000	NURSING SCHOOL	798,175	20.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	373,375	30.00
31.00	03100	INTENSIVE CARE UNIT	47,975	31.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	131,425	44.00
45.00	04500	NURSING FACILITY	8,500	45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	84,800	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,000	54.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	6,000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,500	73.00
76.97	07697	CARDIAC REHABILITATION	13,000	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	43,600	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
90.01	09001	WOUND CLINIC	800	90.01
91.00	09100	EMERGENCY	29,000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	96.00
101.00	10100	HOME HEALTH AGENCY	33,000	101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	13,200	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	798,175	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
193.00	19300	NONPAID WORKERS	0	193.00
193.01	19301	NONPAID WORKERS	0	193.01
193.02	19302	FOUNDATION	0	193.02
194.00	07950	PHYSICIANS CLINIC	0	194.00
194.01	07951	PROCTOR CHEMICAL DEPENDENCY	0	194.01
194.02	07952	ST. FRANCIS RENAL DIALYSIS	0	194.02
194.03	07953	RUCHFORD POB	0	194.03
194.04	07954	EP COLEMAN RENTAL SPACE	0	194.04
194.05	07955	FARMINGTON POB	0	194.05
194.06	07956	LEWISTON POB	0	194.06
194.07	07957	OTHER RENTAL PROPERTY	0	194.07
194.08	07958	KELLEY HOME	0	194.08
194.09	07959	EMPLOYEE PURCHASE	0	194.09
194.10	07960	RETAIL PHARMACY	0	194.10
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)	1,797,344	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2.251817	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/20/2015 10:22 am

		Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)		
			20.00		
204.00		Cost to be allocated (per Wkst. B, Part II)	386,301		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.483980		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/20/2015 10:22 am

Title XVIII | Hospital | PPS

		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	6,901,641		6,901,641	0	6,901,641	30.00
31.00	03100	INTENSIVE CARE UNIT	1,451,690		1,451,690	0	1,451,690	31.00
43.00	04300	NURSERY	483,780		483,780	0	483,780	43.00
44.00	04400	SKILLED NURSING FACILITY	2,568,678		2,568,678	0	2,568,678	44.00
45.00	04500	NURSING FACILITY	1,811,920		1,811,920	0	1,811,920	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,111,234		5,111,234	0	5,111,234	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	189,584		189,584	0	189,584	52.00
53.00	05300	ANESTHESIOLOGY	190,102		190,102	0	190,102	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,984,493		2,984,493	0	2,984,493	54.00
57.00	05700	CT SCAN	470,050		470,050	0	470,050	57.00
58.00	05800	MRI	479,360		479,360	0	479,360	58.00
60.00	06000	LABORATORY	5,147,882		5,147,882	0	5,147,882	60.00
65.00	06500	RESPIRATORY THERAPY	882,543	0	882,543	0	882,543	65.00
66.00	06600	PHYSICAL THERAPY	2,038,336	0	2,038,336	0	2,038,336	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,365,722		1,365,722	0	1,365,722	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,432,317		1,432,317	0	1,432,317	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,645,871		3,645,871	0	3,645,871	73.00
76.97	07697	CARDIAC REHABILITATION	499,244		499,244	0	499,244	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	15,372,735		15,372,735	0	15,372,735	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09001	WOUND CLINIC	572,814		572,814	0	572,814	90.01
91.00	09100	EMERGENCY	2,696,836		2,696,836	15,309	2,712,145	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,018,975		1,018,975		1,018,975	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	1,458,883		1,458,883	0	1,458,883	96.00
101.00	10100	HOME HEALTH AGENCY	1,210,820		1,210,820		1,210,820	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	281,315		281,315		281,315	116.00
200.00		Subtotal (see instructions)	60,266,825	0	60,266,825	15,309	60,282,134	200.00
201.00		Less Observation Beds	1,018,975		1,018,975		1,018,975	201.00
202.00		Total (see instructions)	59,247,850	0	59,247,850	15,309	59,263,159	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/20/2015 10:22 am

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		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	8,749,183		8,749,183			30.00
31.00	03100	INTENSIVE CARE UNIT	2,500,509		2,500,509			31.00
43.00	04300	NURSERY	255,205		255,205			43.00
44.00	04400	SKILLED NURSING FACILITY	1,962,699		1,962,699			44.00
45.00	04500	NURSING FACILITY	1,056,122		1,056,122			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,117,513	12,813,693	18,931,206	0.269990	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	613,922	141,648	755,570	0.250915	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	981,595	1,876,373	2,857,968	0.066516	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,756,670	17,018,950	18,775,620	0.158956	0.000000	54.00
57.00	05700	CT SCAN	1,684,270	11,471,438	13,155,708	0.035730	0.000000	57.00
58.00	05800	MRI	233,273	4,933,775	5,167,048	0.092773	0.000000	58.00
60.00	06000	LABORATORY	4,771,074	20,660,386	25,431,460	0.202422	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	5,211,340	2,377,782	7,589,122	0.116291	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,092,488	3,212,444	6,304,932	0.323292	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,439,608	3,397,493	5,837,101	0.233973	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,750,187	626,746	3,376,933	0.424147	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,871,257	3,535,715	9,406,972	0.387571	0.000000	73.00
76.97	07697	CARDIAC REHABILITATION	205	635,127	635,332	0.785800	0.000000	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	24,773,255	24,773,255			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09001	WOUND CLINIC	10,141	974,977	985,118	0.581467	0.000000	90.01
91.00	09100	EMERGENCY	2,762,297	13,780,902	16,543,199	0.163018	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	306,179	1,007,736	1,313,915	0.775526	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	2,768,433	2,768,433	0.526971	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	939,294	939,294			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	192,541	192,541			116.00
200.00		Subtotal (see instructions)	53,125,737	127,138,708	180,264,445			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	53,125,737	127,138,708	180,264,445			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/20/2015 10:22 am

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
45.00	04500	NURSING FACILITY		45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.269990	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250915	52.00
53.00	05300	ANESTHESIOLOGY	0.066516	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158956	54.00
57.00	05700	CT SCAN	0.035730	57.00
58.00	05800	MRI	0.092773	58.00
60.00	06000	LABORATORY	0.202422	60.00
65.00	06500	RESPIRATORY THERAPY	0.116291	65.00
66.00	06600	PHYSICAL THERAPY	0.323292	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.233973	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.424147	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387571	73.00
76.97	07697	CARDIAC REHABILITATION	0.785800	76.97
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	WOUND CLINIC	0.581467	90.01
91.00	09100	EMERGENCY	0.163943	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.775526	92.00
		OTHER REIMBURSABLE COST CENTERS		
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.526971	96.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part I Date/Time Prepared: 11/20/2015 10:22 am

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	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	609,554	0	609,554	7,464	81.67	30.00
31.00	INTENSIVE CARE UNIT	98,874		98,874	843	117.29	31.00
43.00	NURSERY	31,344		31,344	505	62.07	43.00
44.00	SKILLED NURSING FACILITY	199,630		199,630	4,778	41.78	44.00
45.00	NURSING FACILITY	168,281		168,281	5,740	29.32	45.00
200.00	Total (lines 30-199)	1,107,683		1,107,683	19,330		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)		
		6.00	7.00		
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	2,944	240,436		30.00
31.00	INTENSIVE CARE UNIT	442	51,842		31.00
43.00	NURSERY	0	0		43.00
44.00	SKILLED NURSING FACILITY	3,191	133,320		44.00
45.00	NURSING FACILITY	0	0		45.00
200.00	Total (lines 30-199)	6,577	425,598		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/20/2015 10:22 am

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		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	860,744	18,931,206	0.045467	2,331,494	106,006	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,733	755,570	0.047293	0	0	52.00
53.00	05300	ANESTHESIOLOGY	44,741	2,857,968	0.015655	371,053	5,809	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	500,159	18,775,620	0.026639	954,590	25,429	54.00
57.00	05700	CT SCAN	169,844	13,155,708	0.012910	934,323	12,062	57.00
58.00	05800	MRI	169,621	5,167,048	0.032827	138,245	4,538	58.00
60.00	06000	LABORATORY	401,229	25,431,460	0.015777	2,487,515	39,246	60.00
65.00	06500	RESPIRATORY THERAPY	49,823	7,589,122	0.006565	1,014,881	6,663	65.00
66.00	06600	PHYSICAL THERAPY	119,412	6,304,932	0.018939	377,493	7,149	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	37,356	5,837,101	0.006400	2,184,605	13,981	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	39,178	3,376,933	0.011602	1,279,275	14,842	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	176,851	9,406,972	0.018800	2,243,768	42,183	73.00
76.97	07697	CARDIAC REHABILITATION	49,547	635,332	0.077986	205	16	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	990,982	24,773,255	0.040002	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	47,098	985,118	0.047810	1,264	60	90.01
91.00	09100	EMERGENCY	281,456	16,543,199	0.017013	1,585,816	26,979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	89,996	1,313,915	0.068495	154,349	10,572	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	61,299	2,768,433	0.022142	0	0	96.00
200.00		Total (lines 50-199)	4,125,069	164,608,892		16,058,876	315,535	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part III Date/Time Prepared: 11/20/2015 10:22 am

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		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	840,772	0	0	0	840,772	30.00
31.00	03100	INTENSIVE CARE UNIT	108,031	0	0		108,031	31.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	295,945	0	0		295,945	44.00
45.00	04500	NURSING FACILITY	19,140	0	0		19,140	45.00
200.00		Total (lines 30-199)	1,263,888	0	0		1,263,888	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,464	112.64	2,944	331,612	0	30.00
31.00	03100	INTENSIVE CARE UNIT	843	128.15	442	56,642	0	31.00
43.00	04300	NURSERY	505	0.00	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,778	61.94	3,191	197,651	0	44.00
45.00	04500	NURSING FACILITY	5,740	3.33	0	0	0	45.00
200.00		Total (lines 30-199)	19,330		6,577	585,905	0	200.00

		Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
43.00	04300	NURSERY	0	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0	0				44.00
45.00	04500	NURSING FACILITY	0	0				45.00
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/20/2015 10:22 am

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		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	190,954	0	0	190,954	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	18,015	0	0	18,015	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	13,511	0	0	13,511	66.00
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	12,385	0	0	12,385	73.00
76.97	07697	CARDIAC REHABILITATION	0	29,274	0	0	29,274	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	98,179	0	0	98,179	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	1,801	0	0	1,801	90.01
91.00	09100	EMERGENCY	0	65,303	0	0	65,303	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	124,134	0	0	124,134	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	553,556	0	0	553,556	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/20/2015 10:22 am

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		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	190,954	18,931,206	0.010087	0.010087	2,331,494	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	755,570	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,857,968	0.000000	0.000000	371,053	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,015	18,775,620	0.000959	0.000959	954,590	54.00
57.00	05700	CT SCAN	0	13,155,708	0.000000	0.000000	934,323	57.00
58.00	05800	MRI	0	5,167,048	0.000000	0.000000	138,245	58.00
60.00	06000	LABORATORY	0	25,431,460	0.000000	0.000000	2,487,515	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,589,122	0.000000	0.000000	1,014,881	65.00
66.00	06600	PHYSICAL THERAPY	13,511	6,304,932	0.002143	0.002143	377,493	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,837,101	0.000000	0.000000	2,184,605	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,376,933	0.000000	0.000000	1,279,275	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,385	9,406,972	0.001317	0.001317	2,243,768	73.00
76.97	07697	CARDIAC REHABILITATION	29,274	635,332	0.046077	0.046077	205	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	98,179	24,773,255	0.003963	0.003963	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	WOUND CLINIC	1,801	985,118	0.001828	0.001828	1,264	90.01
91.00	09100	EMERGENCY	65,303	16,543,199	0.003947	0.003947	1,585,816	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	124,134	1,313,915	0.094476	0.094476	154,349	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	2,768,433	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	553,556	164,608,892			16,058,876	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/20/2015 10:22 am

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		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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	23,518	3,382,500	34,119	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	448,709	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	915	4,981,705	4,777	0	0	54.00
57.00	05700	CT SCAN	0	3,713,677	0	0	0	57.00
58.00	05800	MRI	0	1,192,520	0	0	0	58.00
60.00	06000	LABORATORY	0	2,778,025	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	654,040	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	809	8,959	19	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	669,871	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	213,032	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,955	928,209	1,222	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	9	282,995	13,040	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	2	326,210	596	0	0	90.01
91.00	09100	EMERGENCY	6,259	3,466,375	13,682	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	14,582	432,006	40,814	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	49,049	23,478,833	108,269	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/20/2015 10:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		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
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/20/2015 10:22 am

Title XVIII | Hospital | 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	0.269990	3,382,500	0	0	913,241	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250915	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.066516	448,709	0	0	29,846	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158956	4,981,705	0	551	791,872	54.00
57.00	05700	CT SCAN	0.035730	3,713,677	0	0	132,690	57.00
58.00	05800	MRI	0.092773	1,192,520	0	111	110,634	58.00
60.00	06000	LABORATORY	0.202422	2,778,025	1,135	0	562,333	60.00
65.00	06500	RESPIRATORY THERAPY	0.116291	654,040	0	0	76,059	65.00
66.00	06600	PHYSICAL THERAPY	0.323292	8,959	0	0	2,896	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.233973	669,871	0	14	156,732	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.424147	213,032	0	0	90,357	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387571	928,209	0	3,646	359,747	73.00
76.97	07697	CARDIAC REHABILITATION	0.785800	282,995	0	0	222,377	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.581467	326,210	0	0	189,680	90.01
91.00	09100	EMERGENCY	0.163018	3,466,375	1	0	565,082	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.775526	432,006	0	0	335,032	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.526971	0	0	0	0	96.00
200.00		Subtotal (see instructions)		23,478,833	1,136	4,322	4,538,578	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		23,478,833	1,136	4,322	4,538,578	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/20/2015 10:22 am

Title XVIII | Hospital | 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	88		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	10		58.00
60.00	06000	LABORATORY	230	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,413		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	230	1,514		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	230	1,514		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/20/2015 10:22 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	190,954	0	0	190,954	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	18,015	0	0	18,015	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	13,511	0	0	13,511	66.00
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	12,385	0	0	12,385	73.00
76.97	07697	CARDIAC REHABILITATION	0	29,274	0	0	29,274	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	98,179	0	0	98,179	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0	1,801	0	0	1,801	90.01
91.00	09100	EMERGENCY	0	65,303	0	0	65,303	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	429,422	0	0	429,422	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/20/2015 10:22 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	190,954	18,931,206	0.010087	0.010087	362,803	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	755,570	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,857,968	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,015	18,775,620	0.000959	0.000959	9,058	54.00
57.00	05700	CT SCAN	0	13,155,708	0.000000	0.000000	253	57.00
58.00	05800	MRI	0	5,167,048	0.000000	0.000000	0	58.00
60.00	06000	LABORATORY	0	25,431,460	0.000000	0.000000	17,203	60.00
65.00	06500	RESPIRATORY THERAPY	0	7,589,122	0.000000	0.000000	307,822	65.00
66.00	06600	PHYSICAL THERAPY	13,511	6,304,932	0.002143	0.002143	1,688,451	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	5,837,101	0.000000	0.000000	247,069	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,376,933	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,385	9,406,972	0.001317	0.001317	239,341	73.00
76.97	07697	CARDIAC REHABILITATION	29,274	635,332	0.046077	0.046077	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	98,179	24,773,255	0.003963	0.003963	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	WOUND CLINIC	1,801	985,118	0.001828	0.001828	326	90.01
91.00	09100	EMERGENCY	65,303	16,543,199	0.003947	0.003947	534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,313,915	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	2,768,433	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	429,422	164,608,892			2,872,860	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/20/2015 10:22 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)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
			11.00	12.00	13.00	21.00	22.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,660	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	9	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,618	0	0	0	0	66.00
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	315	0	0	0	0	73.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	1	0	0	0	0	90.01
91.00	09100	EMERGENCY	2	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
200.00		Total (lines 50-199)	7,605	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/20/2015 10:22 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost		
			23.00	24.00		
		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
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/20/2015 10:22 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	0.269990	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250915	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.066516	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158956	0	0	47	0	54.00
57.00	05700	CT SCAN	0.035730	0	0	0	0	57.00
58.00	05800	MRI	0.092773	0	0	7	0	58.00
60.00	06000	LABORATORY	0.202422	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.116291	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.323292	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.233973	0	0	1	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.424147	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387571	0	0	1,285	0	73.00
76.97	07697	CARDIAC REHABILITATION	0.785800	0	0	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WOUND CLINIC	0.581467	0	0	0	0	90.01
91.00	09100	EMERGENCY	0.163018	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.775526	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.526971	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	0	1,340	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	1,340	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/20/2015 10:22 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	7		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	1		58.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	498		73.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	WOUND CLINIC	0	0		90.01
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
200.00		Subtotal (see instructions)	0	506		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	506		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/20/2015 10:22 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,464	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,464	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)	6,362	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)	2,944	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	6,901,641	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)	6,901,641	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)	6,901,641	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)	924.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,722,199	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)	2,722,199	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/20/2015 10:22 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	1,451,690	843	1,722.05	442	761,146	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)	3,899,637	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	7,382,982	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)	680,532	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	364,584	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,045,116	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	6,337,866	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	1,102	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	924.66	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,018,975	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/20/2015 10:22 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	609,554	6,901,641	0.088320	1,018,975	89,996	90.00
91.00	Nursing School cost	840,772	6,901,641	0.121822	1,018,975	124,134	91.00
92.00	Allied health cost	0	6,901,641	0.000000	1,018,975	0	92.00
93.00	All other Medical Education	0	6,901,641	0.000000	1,018,975	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140001	Period: From 07/01/2014	Worksheet D-1
Component CCN: 145572	To 06/30/2015	Date/Time Prepared: 11/20/2015 10:22 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)	4,778	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,778	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)	4,778	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)	3,191	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	2,568,678	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)	2,568,678	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)	2,568,678	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: 140001 | Component CCN: 145572 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/20/2015 10:22 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/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,568,678	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	537.61	71.00
72.00	Program routine service cost (line 9 x line 71)	1,715,514	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)	1,715,514	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)	1,715,514	83.00
84.00	Program inpatient ancillary services (see instructions)	835,390	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)	2,550,904	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: 140001 Component CCN: 145572	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/20/2015 10:22 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: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/20/2015 10:22 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		3,496,440		30.00
31.00	03100	INTENSIVE CARE UNIT		1,047,265		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.269990	2,331,494	629,480	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250915	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.066516	371,053	24,681	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158956	954,590	151,738	54.00
57.00	05700	CT SCAN	0.035730	934,323	33,383	57.00
58.00	05800	MRI	0.092773	138,245	12,825	58.00
60.00	06000	LABORATORY	0.202422	2,487,515	503,528	60.00
65.00	06500	RESPIRATORY THERAPY	0.116291	1,014,881	118,022	65.00
66.00	06600	PHYSICAL THERAPY	0.323292	377,493	122,040	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.233973	2,184,605	511,139	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.424147	1,279,275	542,601	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387571	2,243,768	869,619	73.00
76.97	07697	CARDIAC REHABILITATION	0.785800	205	161	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.581467	1,264	735	90.01
91.00	09100	EMERGENCY	0.163943	1,585,816	259,983	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.775526	154,349	119,702	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.526971	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		16,058,876	3,899,637	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)		16,058,876		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140001 | Component CCN: 145572 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/20/2015 10:22 am

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		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.269990	362,803	97,953	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.250915	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.066516	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.158956	9,058	1,440	54.00
57.00	05700	CT SCAN	0.035730	253	9	57.00
58.00	05800	MRI	0.092773	0	0	58.00
60.00	06000	LABORATORY	0.202422	17,203	3,482	60.00
65.00	06500	RESPIRATORY THERAPY	0.116291	307,822	35,797	65.00
66.00	06600	PHYSICAL THERAPY	0.323292	1,688,451	545,863	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.233973	247,069	57,807	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.424147	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.387571	239,341	92,762	73.00
76.97	07697	CARDIAC REHABILITATION	0.785800	0	0	76.97
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	WOUND CLINIC	0.581467	326	190	90.01
91.00	09100	EMERGENCY	0.163018	534	87	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.775526	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.526971	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		2,872,860	835,390	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,872,860		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A | Date/Time Prepared: 11/20/2015 10:22 am

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		1,292,647			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,999,351			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0			1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0			1.04
2.00	Outlier payments for discharges. (see instructions)		77,329			2.00
2.01	Outlier reconciliation amount		0			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0			2.02
3.00	Managed Care Simulated Payments		0			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		39.98			4.00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00			5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00			6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00			7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00			7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00			8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00			8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00			9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00			10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00			11.00
12.00	Current year allowable FTE (see instructions)		0.00			12.00
13.00	Total allowable FTE count for the prior year.		0.00			13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00			14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00			15.00
16.00	Adjustment for residents in initial years of the program		0.00			16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00			17.00
18.00	Adjusted rolling average FTE count		0.00			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000			21.00
22.00	IME payment adjustment (see instructions)		0			22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00			23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00			24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00			25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000			26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000			27.00
28.00	IME add-on adjustment amount (see instructions)		0			28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0			28.01
29.00	Total IME payment (sum of lines 22 and 28)		0			29.00

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0			29.01
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.43			30.00
31.00	Percentage of Medicaid patient days (see instructions)		22.94			31.00
32.00	Sum of lines 30 and 31		26.37			32.00
33.00	Allowable disproportionate share percentage (see instructions)		10.97			33.00
34.00	Disproportionate share adjustment (see instructions)		145,133			34.00

			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143		7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000057096		0.000048212	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		516,514		368,708	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		130,190		275,773	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		405,963			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		5,920,423			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		6,670,721			48.00
49.00	Total payment for inpatient operating costs (see instructions)		6,670,721			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		425,237			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		509,372			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		388,254			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		49,049			58.00
59.00	Total (sum of amounts on lines 49 through 58)		8,042,633			59.00
60.00	Primary payer payments		0			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		8,042,633			61.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Date/Time Prepared: 11/20/2015 10:22 am

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			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
62.00	Deductibles billed to program beneficiaries		814,252			62.00
63.00	Coinsurance billed to program beneficiaries		3,150			63.00
64.00	Allowable bad debts (see instructions)		202,549			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		131,657			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		160,912			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		7,356,888			67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0			68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0			69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			70.00
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0			70.91
70.92	Bundled Model 1 discount amount (see instructions)		0			70.92
70.93	HVBP payment adjustment amount (see instructions)		-14,426			70.93
70.94	HRR adjustment amount (see instructions)		-93,757			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	2014	72,914			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	2015	273,685			70.97
70.98	Low Volume Payment-3		0			70.98
70.99	HAC adjustment amount (see instructions)		0			70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		7,595,304			71.00
71.01	Sequestration adjustment (see instructions)		151,906			71.01
72.00	Interim payments		7,241,998			72.00
73.00	Tentative settlement (for contractor use only)		0			73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		201,400			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0			75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0			90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Date/Time Prepared: 11/20/2015 10:22 am

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		Prior to 10/1		On/After 10/1	
		1.00	1.01	2.00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)	0		0	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0		0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0		0	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0		0	104.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet DSH | Date/Time Prepared: 11/20/2015 10:22 am

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		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF THE DSH PAYMENT PERCENTAGE						
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	3.43	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	22.94	0.00			22.94	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	26.37	0.00			22.94	3.00
4.00	Provider Type * (urban, rural,SCH, RRC, pickle - If pickle worksheet NA)	SCH				SCH	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	39.98	0.00			39.98	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	10.97	0.00			8.14	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				Yes	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	No				No	9.00
10.00	S-2, Line 45	No				No	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 geater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	No				No	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	0.00	0.00	0.00	0.00	0.00	14.00
	CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS						
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	1,601	0			1,601	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	0	0			0	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	183	0			183	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	1,784	0			1,784	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	7,710	0			7,710	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	0	0			0	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	67	0			67	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	7,777	0			7,777	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	22.94	0.00			22.94	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet DSH | Date/Time Prepared: 11/20/2015 10:22 am

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		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	10.97		0.00	True	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	False	0.00		0.00	False	29.00
30.00	Line 28 or 29 as applicable		10.97		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		10.97		0.00		31.00

		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
	DETERMINATION OF PROVIDER TYPE						
32.00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	True				True	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Rural				Rural	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet DSH | Date/Time Prepared: 11/20/2015 10:22 am

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		Revised Percentage 6.00		
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE			
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	8.14		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	0.00		29.00
30.00	Line 28 or 29 as applicable	8.14		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	8.14		31.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/20/2015 10:22 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,292,647	0	1,292,647	0	1,292,647	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,999,351	0	0	3,999,351	3,999,351	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	77,329	0	18,736	58,593	77,329	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1097	0.1097	0.1097	0.1097		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	145,133	0	35,451	109,682	145,133	11.00
11.01	Uncompensated care payments	36.00	405,963	0	130,190	275,773	405,963	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,920,423	0	1,477,024	4,443,399	5,920,423	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	6,670,721	0	1,576,435	5,094,286	6,670,721	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,670,721	0	1,576,435	5,094,286	6,670,721	15.00
16.00	Payment for inpatient program capital	50.00	425,237	0	103,873	321,364	425,237	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 11/20/2015 10:22 am

Title XVIII | Hospital | PPS

		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	1,680,308	5,415,650	7,095,958	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	416,738	0	101,820	314,918	416,738	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	8,499	0	2,053	6,446	8,499	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	425,237	0	103,873	321,364	425,237	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.043393	0.050536		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			72,914		72,914	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				273,685	273,685	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/20/2015 10:22 am

Title XVIII | Hospital | PPS

		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,292,647	1,292,647		1,292,647	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,999,351		3,999,351	3,999,351	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	77,329	18,736	58,593	77,329	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1097	0.1097	0.1097		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	145,133	35,451	109,682	145,133	11.00
11.01	Uncompensated care payments	36.00	405,963	130,189	386,323	516,512	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	5,920,423	1,477,023	4,443,400	5,920,423	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	6,670,721	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,670,721	0	6,670,721	6,670,721	15.00
16.00	Payment for inpatient program capital	50.00	425,237	103,873	321,364	425,237	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			103,873	6,992,085	7,095,958	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/20/2015 10:22 am

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	416,738	101,820	314,918	416,738	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	8,499	2,053	6,446	8,499	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	425,237	103,873	321,364	425,237	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	72,914	72,914		72,914	28.00
29.00	Low volume adjustment on or after October 1	70.97	273,685		273,685	273,685	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	-14,426	-3,897	-10,529	-14,426	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-93,757	-15,770	-77,987	-93,757	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part B Date/Time Prepared: 11/20/2015 10:22 am

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,744	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	4,430,309	2.00
3.00	PPS payments	3,925,775	3.00
4.00	Outlier payment (see instructions)	4,243	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.862	5.00
6.00	Line 2 times line 5	3,818,926	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	108,269	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	1,744	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	5,458	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	5,458	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)	5,458	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	3,714	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)	1,744	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)	4,038,287	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)	895,035	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,144,996	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,144,996	30.00
31.00	Primary payer payments	850	31.00
32.00	Subtotal (line 30 minus line 31)	3,144,146	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)	167,723	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	109,020	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	130,767	36.00
37.00	Subtotal (see instructions)	3,253,166	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-38	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,253,204	40.00
40.01	Sequestration adjustment (see instructions)	65,064	40.01
41.00	Interim payments	3,179,823	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	8,317	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
		Overrides 1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/20/2015 10:22 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	506	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)	506	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	1,340	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	1,340	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)	1,340	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	834	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)	506	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] (see instructions)	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)	506	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	506	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)	506	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)	506	40.00
40.01	Sequestration adjustment (see instructions)	10	40.01
41.00	Interim payments	407	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	89	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
		Overrides	
		1.00	
	WORKSHEET OVERRIDE VALUES		
112.00	Override of Ancillary service charges (line 12)	0	112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2015 10:22 am

Title XVIII | Hospital | 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		7,068,007		3,179,823	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	06/18/2015	173,991		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)		173,991		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)		7,241,998		3,179,823	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		201,400		8,317	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		7,443,398		3,188,140	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: 140001 | Component CCN: 145572 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/20/2015 10:22 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		1,208,434		407	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)		1,208,434		407	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		201,150		89	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,409,584		496	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: 140001	Period: From 07/01/2014 To 06/30/2015	Worksheet E-1 Part II Date/Time Prepared: 11/20/2015 10:22 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	2,090	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	3,386	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	1,299	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	7,205	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	180,264,445	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	3,768,090	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)	726,592	8.00
9.00	Sequestration adjustment amount (see instructions)	14,532	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	712,060	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	730,151	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)	-18,091	32.00
		Overrides	
		1.00	
	CONTRACTOR OVERRIDES		
108.00	Override of HIT payment	0	108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140001 Component CCN: 145572	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VI Date/Time Prepared: 11/20/2015 10:22 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)	1,400,284	1.00
2.00	Routine service other pass through costs	197,651	2.00
3.00	Ancillary service other pass through costs	7,605	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,605,540	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	163,340	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)	1,442,200	12.00
13.00	Inpatient primary payer payments	3,849	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	1,438,351	15.00
15.01	Sequestration adjustment (see instructions)	28,767	15.01
16.00	Interim payments	1,208,434	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)	201,150	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: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/20/2015 10:22 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	5,544,071	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	9,612,498	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	1,345,498	0	0	0	7.00
8.00	Prepaid expenses	1,394,051	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	17,896,118	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	5,050,535	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	64,374,472	0	0	0	15.00
16.00	Accumulated depreciation	-56,643,256	0	0	0	16.00
17.00	Leasehold improvements	506,639	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	28,658,921	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	11,827,404	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)	53,774,715	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	65,817,077	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	11,501,882	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	77,318,959	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	148,989,792	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,495,819	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,206,755	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	860,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	2,552,361	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	10,114,935	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	25,895,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	8,411,602	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	34,306,602	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	44,421,537	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	104,568,255				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)	104,568,255	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	148,989,792	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/20/2015 10:22 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		99,209,273		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,358,982				2.00
3.00	Total (sum of line 1 and line 2)		104,568,255		0		3.00
4.00	ROUNDING	3		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)		3		0		10.00
11.00	Subtotal (line 3 plus line 10)		104,568,258		0		11.00
12.00	ROUNDING	3		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)		3		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		104,568,255		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	ROUNDING		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	ROUNDING		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/20/2015 10:22 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	10,176,062		10,176,062	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	1,962,699		1,962,699	7.00
8.00	NURSING FACILITY	1,056,122		1,056,122	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	13,194,883		13,194,883	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	2,515,451		2,515,451	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)	2,515,451		2,515,451	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	15,710,334		15,710,334	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	24,773,255	24,773,255	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		939,294	939,294	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	1	192,540	192,541	26.00
27.00	DME	0	2,768,433	2,768,433	27.00
27.01	OPERATING ROOM	10,325,151	15,917,187	26,242,338	27.01
27.02	DELIVERY ROOM & LABOR ROOM	632,449	144,312	776,761	27.02
27.03	ANESTHESIOLOGY	2,696,423	4,827,521	7,523,944	27.03
27.04	RADIOLOGY-DIAGNOSTIC	1,769,519	17,453,623	19,223,142	27.04
27.05	CT SCAN	1,702,990	11,680,918	13,383,908	27.05
27.06	MRI	241,262	5,045,947	5,287,209	27.06
27.07	LABORATORY	4,902,609	21,457,827	26,360,436	27.07
27.08	RESPIRATORY THERAPY	5,224,647	2,426,454	7,651,101	27.08
27.09	PHYSICAL THERAPY	3,100,682	3,371,266	6,471,948	27.09
27.10	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,214,712	1,597,932	2,812,644	27.10
27.11	IMPL. DEV. CHARGED TO PATIENT	0	0	0	27.11
27.12	DRUGS CHARGED TO PATIENTS	5,939,765	3,629,954	9,569,719	27.12
27.13	CARDIAC REHAB	205	644,573	644,778	27.13
27.14	NURSING ADMIN	5,189	31,126	36,315	27.14
27.15	DIETARY	0	31,018	31,018	27.15
27.16	PHYSICIAN	0	327,789	327,789	27.16
27.17	NURSERY	261,127	0	261,127	27.17
27.18	EMERGENCY	3,878,889	19,659,894	23,538,783	27.18
27.19	WOUND CLINIC	11,301	1,414,637	1,425,938	27.19
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	57,617,255	138,335,500	195,952,755	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		74,050,969		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		74,050,969		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140001 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-3 | Date/Time Prepared: 11/20/2015 10:22 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	195,952,755	1.00
2.00	Less contractual allowances and discounts on patients' accounts	120,172,371	2.00
3.00	Net patient revenues (line 1 minus line 2)	75,780,384	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	74,050,969	4.00
5.00	Net income from service to patients (line 3 minus line 4)	1,729,415	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	78,644	6.00
7.00	Income from investments	5,011,984	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	0	23.00
24.00	GHA ACCRUED NET PATIENT REVENUE	67,560	24.00
24.01	CHANGE IN BENE. INT. PERPETUAL TRUST	0	24.01
24.02	NET ASSETS RELEASED FROM RESTRICTION	96,153	24.02
24.03	INCREASE IN TEMP. RESTRICTED ASSETS	50,369	24.03
24.05	CY CHANGE IN UNREALIZED GAINS	0	24.05
24.06	OTHER OPERATING REVENUE	3,371,687	24.06
25.00	Total other income (sum of lines 6-24)	8,676,397	25.00
26.00	Total (line 5 plus line 25)	10,405,812	26.00
27.00	PROVISION FOR UNCOLLECTIBLE ACCOUNTS	1,939,582	27.00
27.01	CHANGE IN FV OF INT. RATE SWAP AGREE	309,290	27.01
27.02	CHANGE IN BENE. INT. PERPETUAL TRUST	300,883	27.02
27.03	CY CHANGE IN UNREALIZED GAINS	2,496,521	27.03
27.04	ROUNDING	554	27.04
28.00	Total other expenses (sum of line 27 and subscripts)	5,046,830	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,358,982	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140001 | HHA CCN: 147142 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H | Date/Time Prepared: 11/20/2015 10:22 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	118,154	0	0	0	217,315	335,469	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	305,574	0	14,326	0	0	319,900	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	7,289	7,289	9.00
10.00	Medical Social Services	23,908	0	0	0	0	23,908	10.00
11.00	Home Health Aide	32,242	0	0	0	0	32,242	11.00
12.00	Supplies (see instructions)	0	0	0	0	20,861	20,861	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)	479,878	0	14,326	0	245,465	739,669	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	4,955	340,424	-1,258	339,166			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	319,900	0	319,900			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	7,289	0	7,289			9.00
10.00	Medical Social Services	0	23,908	0	23,908			10.00
11.00	Home Health Aide	0	32,242	0	32,242			11.00
12.00	Supplies (see instructions)	0	20,861	0	20,861			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)	4,955	744,624	-1,258	743,366			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: 140001 HHA CCN: 147142 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-1 Part I Date/Time Prepared: 11/20/2015 10:22 am

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			Capital Related Costs					
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bldgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	339,166	0	0	0	0	339,166	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	319,900	0	0	0	0	319,900	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	7,289	0	0	0	0	7,289	9.00
10.00	Medical Social Services	23,908	0	0	0	0	23,908	10.00
11.00	Home Health Aide	32,242	0	0	0	0	32,242	11.00
12.00	Supplies (see instructions)	20,861	0	0	0	0	20,861	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)	743,366	0	0	0	0	743,366	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	339,166						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	268,430	588,330					6.00
7.00	Physical Therapy	0	0					7.00
8.00	Occupational Therapy	0	0					8.00
9.00	Speech Pathology	6,116	13,405					9.00
10.00	Medical Social Services	20,061	43,969					10.00
11.00	Home Health Aide	27,054	59,296					11.00
12.00	Supplies (see instructions)	17,505	38,366					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)		743,366					24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140001 | HHA CCN: 147142 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-1 Part II | Date/Time Prepared: 11/20/2015 10:22 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	-339,166	404,200	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	319,900	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	7,289	9.00
10.00	Medical Social Services	0	0	0	0	0	23,908	10.00
11.00	Home Health Aide	0	0	0	0	0	32,242	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	20,861	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	-339,166	404,200	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		339,166	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.839104	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140001 HHA CCN: 147142 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-2 Part I Date/Time Prepared: 11/20/2015 10:22 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	1.01	2.00	4.00	4A	
1.00	Administrative and General	0	0	0	6,255	111,841	118,096	1.00
2.00	Skilled Nursing Care	588,330	0	0	0	0	588,330	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	13,405	0	0	0	0	13,405	5.00
6.00	Medical Social Services	43,969	0	0	0	0	43,969	6.00
7.00	Home Health Aide	59,296	0	0	0	0	59,296	7.00
8.00	Supplies (see instructions)	38,366	0	0	0	0	38,366	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)	743,366	0	0	6,255	111,841	861,462	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

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	29,879	0	0	4,758	0	0	1.00
2.00	Skilled Nursing Care	148,852	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	3,392	0	0	0	0	0	5.00
6.00	Medical Social Services	11,124	0	0	0	0	0	6.00
7.00	Home Health Aide	15,002	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	9,707	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)	217,956	0	0	4,758	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

(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: 140001 | HHA CCN: 147142 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-2 Part I | Date/Time Prepared: 11/20/2015 10:22 am

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	Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal	
		13.00	14.00	15.00	16.00	20.00	24.00	
1.00	Administrative and General	0	0	0	0	74,310	227,043	1.00
2.00	Skilled Nursing Care	52,265	0	0	0	0	789,447	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	16,797	5.00
6.00	Medical Social Services	0	0	0	0	0	55,093	6.00
7.00	Home Health Aide	0	0	0	0	0	74,298	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	48,073	8.00
9.00	Drugs	0	0	69	0	0	69	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)	52,265	0	69	0	74,310	1,210,820	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	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	227,043					1.00
2.00	Skilled Nursing Care	0	789,447	182,193	971,640			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	16,797	3,877	20,674			5.00
6.00	Medical Social Services	0	55,093	12,715	67,808			6.00
7.00	Home Health Aide	0	74,298	17,147	91,445			7.00
8.00	Supplies (see instructions)	0	48,073	11,095	59,168			8.00
9.00	Drugs	0	69	16	85			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	0	1,210,820	227,043	1,210,820			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.			0.230787				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: 140001 HHA CCN: 147142 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-2 Part II Date/Time Prepared: 11/20/2015 10:22 am

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	Cost Center Description	CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	1.01	2.00	4.00	5A	5.00	
1.00	Administrative and General	0	0	6,220	479,877	0	118,096	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	588,330	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	13,405	5.00
6.00	Medical Social Services	0	0	0	0	0	43,969	6.00
7.00	Home Health Aide	0	0	0	0	0	59,296	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	38,366	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	6,220	479,877		861,462	20.00
21.00	Total cost to be allocated	0	0	6,255	111,841		217,956	21.00
22.00	Unit cost multiplier	0.000000	0.000000	1.005627	0.233062		0.253007	22.00

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	111	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	907	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	111	0	0	907	20.00
21.00	Total cost to be allocated	0	0	4,758	0	0	52,265	21.00
22.00	Unit cost multiplier	0.000000	0.000000	42.864865	0.000000	0.000000	57.624035	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140001 HHA CCN: 147142

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

Worksheet H-2 Part II Date/Time Prepared: 11/20/2015 10:22 am

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	Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	NURSING SCHOOL (ASSIGNED TIME)			
		14.00	15.00	16.00	20.00			
1.00	Administrative and General	0	0	0	33,000			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	20,095	159	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19)	20,095	159	0	33,000			20.00
21.00	Total cost to be allocated	0	69	0	74,310			21.00
22.00	Unit cost multiplier	0.000000	0.433962	0.000000	2.251818			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140001 | HHA CCN: 147142 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-3 Part I | Date/Time Prepared: 11/20/2015 10:22 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	971,640		971,640	2,553	380.59	1.00
2.00	Physical Therapy	3.00	0	0	0	715	0.00	2.00
3.00	Occupational Therapy	4.00	0	0	0	317	0.00	3.00
4.00	Speech Pathology	5.00	20,674	0	20,674	69	299.62	4.00
5.00	Medical Social Services	6.00	67,808		67,808	30	2,260.27	5.00
6.00	Home Health Aide	7.00	91,445		91,445	641	142.66	6.00
7.00	Total (sum of lines 1-6)		1,151,567	0	1,151,567	4,325		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	993			8.00
8.01	Skilled Nursing Care		37900	0	48			8.01
8.02	Skilled Nursing Care		44100	0	0			8.02
9.00	Physical Therapy		99914	0	380			9.00
9.01	Physical Therapy		37900	0	19			9.01
9.02	Physical Therapy		44100	0	0			9.02
10.00	Occupational Therapy		99914	0	195			10.00
10.01	Occupational Therapy		37900	0	16			10.01
10.02	Occupational Therapy		44100	0	0			10.02
11.00	Speech Pathology		99914	0	39			11.00
11.01	Speech Pathology		37900	0	0			11.01
11.02	Speech Pathology		44100	0	0			11.02
12.00	Medical Social Services		99914	0	15			12.00
12.01	Medical Social Services		37900	0	0			12.01
12.02	Medical Social Services		44100	0	0			12.02
13.00	Home Health Aide		99914	0	309			13.00
13.01	Home Health Aide		37900	0	18			13.01
13.02	Home Health Aide		44100	0	0			13.02
14.00	Total (sum of lines 8-13)			0	2,032			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	59,168	0	59,168	47,113	1.255874	15.00
16.00	Cost of Drugs	9.00	85	0	85	0	0.000000	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,041		0	396,194		1.00
2.00	Physical Therapy	0	399		0	0		2.00
3.00	Occupational Therapy	0	211		0	0		3.00
4.00	Speech Pathology	0	39		0	11,685		4.00
5.00	Medical Social Services	0	15		0	33,904		5.00
6.00	Home Health Aide	0	327		0	46,650		6.00
7.00	Total (sum of lines 1-6)	0	2,032		0	488,433		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140001 | HHA CCN: 147142 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-3 Part I | Date/Time Prepared: 11/20/2015 10:22 am

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

		Program Covered Charges			Cost of Services			
			Part B			Part B		
	Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	47,113	0	0	59,168	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	396,194	1.00
2.00	Physical Therapy	0	2.00
3.00	Occupational Therapy	0	3.00
4.00	Speech Pathology	11,685	4.00
5.00	Medical Social Services	33,904	5.00
6.00	Home Health Aide	46,650	6.00
7.00	Total (sum of lines 1-6)	488,433	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
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
9.02	Physical Therapy		9.02
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
10.02	Occupational Therapy		10.02
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
11.02	Speech Pathology		11.02
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
12.02	Medical Social Services		12.02
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
13.02	Home Health Aide		13.02
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140001 | HHA CCN: 147142 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-3 Part II | Date/Time Prepared: 11/20/2015 10:22 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	0.323292	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy							2.00
3.00	Speech Pathology							3.00
4.00	Cost of Medical Supplies	71.00	0.233973	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.387571	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140001 | HHA CCN: 147142 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/20/2015 10:22 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	272,150	145,406	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)	272,150	145,406	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	272,150	145,406	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	300,176	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	9,070	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	15,995	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	464	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	2,943	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	328,648	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	328,648	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	328,648	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	328,648	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	328,648	31.00
31.01	Sequestration adjustment (see instructions)	0	6,420	31.01
32.00	Interim payments (see instructions)	0	322,075	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	153	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 140001 HHA CCN: 147142

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

Worksheet H-5

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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		322,075	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		322,075	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		153	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		322,228	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2014 To 06/30/2015 | Worksheet K | Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

		Salaries (from Wkst. K-1)	Employee Benefits (from Wkst. K-2)	Transportation (see inst.)	Contracted Services (from Wkst. K-3)	Other	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	124,583	0	0	1,490	24,991	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	124,583	0	0	1,490	24,991	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2014 To 06/30/2015 | Worksheet K | Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

		Total (cols. 1-5)	Reclassification	Subtotal (col. 6 ± col. 7)	Adjustments	Total (col. 8 ± col. 9)	
		6.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	151,064	4,956	156,020	0	156,020	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	151,064	4,956	156,020	0	156,020	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-1

Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	53,249	0	0	0	36,476	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	53,249	0	0	0	36,476	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-1

Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		3,898	30,960	124,583		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	3,898	30,960	124,583		39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-3

Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

		Administrator	Director	Social Services	Supervisors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	0	0	0	39.00

HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES | Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2014 To 06/30/2015 | Worksheet K-3 | Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

		Total Therapists	Aides	All-Other	Total (1)		
		6.00	7.00	8.00	9.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0	0	0		3.00
4.00	Transportation - Staff		0	0	0		4.00
5.00	Volunteer Service Coordination		0	0	0		5.00
6.00	Administrative and General		0	0	0		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		0	0	0		7.00
8.00	Inpatient - Respite Care		0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services		0	0	0		9.00
10.00	Nursing Care		0	1,490	1,490		10.00
11.00	Nursing Care-Continuous Home Care		0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services		0	0	0		15.00
16.00	Spiritual Counseling		0	0	0		16.00
17.00	Dietary Counseling		0	0	0		17.00
18.00	Counseling - Other		0	0	0		18.00
19.00	Home Health Aide and Homemaker		0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0	0	0		20.00
21.00	Other		0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Analgesics						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation		0	0	0		27.00
28.00	Imaging Services		0	0	0		28.00
29.00	Labs and Diagnostics		0	0	0		29.00
30.00	Medical Supplies		0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0		31.00
32.00	Radiation Therapy		0	0	0		32.00
33.00	Chemotherapy		0	0	0		33.00
34.00	Other		0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0	0	0		35.00
36.00	Volunteer Program Costs		0	0	0		36.00
37.00	Fundraising		0	0	0		37.00
38.00	Other Program Costs		0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	0	1,490	1,490		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-4 Part I Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

		NET EXPENSES FOR COST ALLOCATION	CAPITAL RELATED COST		PLANT OPERATION & MAINT.	TRANSPORTATION	
			BUILDINGS & FIXTURES	MOVABLE EQUIPMENT			
		0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	0		0			2.00
3.00	Plant Operation and Maintenance	0	0	0	0		3.00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	156,020	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	156,020	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-4 Part I Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

		VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5A ± col. 6)		
		5.00	5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance						3.00
4.00	Transportation - Staff						4.00
5.00	Volunteer Service Coordination	0					5.00
6.00	Administrative and General	0	0	0			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0		7.00
8.00	Inpatient - Respite Care	0	0	0	0		8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0		9.00
10.00	Nursing Care	0	156,020	0	156,020		10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0		11.00
12.00	Physical Therapy	0	0	0	0		12.00
13.00	Occupational Therapy	0	0	0	0		13.00
14.00	Speech/ Language Pathology	0	0	0	0		14.00
15.00	Medical Social Services	0	0	0	0		15.00
16.00	Spiritual Counseling	0	0	0	0		16.00
17.00	Dietary Counseling	0	0	0	0		17.00
18.00	Counseling - Other	0	0	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		20.00
21.00	Other	0	0	0	0		21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0		22.00
23.00	Analgesics	0	0	0	0		23.00
24.00	Sedatives / Hypnotics	0	0	0	0		24.00
25.00	Other - Specify	0	0	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0		26.00
27.00	Patient Transportation	0	0	0	0		27.00
28.00	Imaging Services	0	0	0	0		28.00
29.00	Labs and Diagnostics	0	0	0	0		29.00
30.00	Medical Supplies	0	0	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0		31.00
32.00	Radiation Therapy	0	0	0	0		32.00
33.00	Chemotherapy	0	0	0	0		33.00
34.00	Other	0	0	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0		35.00
36.00	Volunteer Program Costs	0	0	0	0		36.00
37.00	Fundraising	0	0	0	0		37.00
38.00	Other Program Costs	0	0	0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0	156,020		156,020		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2014 To 06/30/2015 | Worksheet K-4 Part II Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

		CAPITAL RELATED COST					
		BUILDINGS & FIXTURES (SQ. FT.)	MOVABLE EQUIPMENT ($ VALUE)	PLANT OPERATION & MAINT. (SQ. FT.)	TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICES COORDINATOR (HOURS)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0	0			3.00
4.00	Transportation - Staff	0	0	0	0		4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5.00
6.00	Administrative and General	0	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7.00
8.00	Inpatient - Respite Care	0	0	0	0	0	8.00
	VISITING SERVICES						
9.00	Physician Services	0	0	0	0	0	9.00
10.00	Nursing Care	0	0	0	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	0	0	0	11.00
12.00	Physical Therapy	0	0	0	0	0	12.00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14.00	Speech/ Language Pathology	0	0	0	0	0	14.00
15.00	Medical Social Services	0	0	0	0	0	15.00
16.00	Spiritual Counseling	0	0	0	0	0	16.00
17.00	Dietary Counseling	0	0	0	0	0	17.00
18.00	Counseling - Other	0	0	0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0	0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	22.00
23.00	Analgesics	0	0	0	0	0	23.00
24.00	Sedatives / Hypnotics	0	0	0	0	0	24.00
25.00	Other - Specify	0	0	0	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	26.00
27.00	Patient Transportation	0	0	0	0	0	27.00
28.00	Imaging Services	0	0	0	0	0	28.00
29.00	Labs and Diagnostics	0	0	0	0	0	29.00
30.00	Medical Supplies	0	0	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33.00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	0	0	0	35.00
36.00	Volunteer Program Costs	0	0	0	0	0	36.00
37.00	Fundraising	0	0	0	0	0	37.00
38.00	Other Program Costs	0	0	0	0	0	38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0	0	0	0	39.00
40.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	40.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140001 Hospice CCN: 141558 | Period: From 07/01/2014 To 06/30/2015 | Worksheet K-4 Part II Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

		RECONCILIATION	ADMINISTRATIVE & GENERAL (ACC. COST)		
		6A	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related Costs-Bldg and Fixt.	0			1.00
2.00	Capital Related Costs-Movable Equip.	0			2.00
3.00	Plant Operation and Maintenance	0			3.00
4.00	Transportation - Staff	0			4.00
5.00	Volunteer Service Coordination				5.00
6.00	Administrative and General	0	156,020		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	0		7.00
8.00	Inpatient - Respite Care	0	0		8.00
	VISITING SERVICES				
9.00	Physician Services	0	0		9.00
10.00	Nursing Care	0	156,020		10.00
11.00	Nursing Care-Continuous Home Care	0	0		11.00
12.00	Physical Therapy	0	0		12.00
13.00	Occupational Therapy	0	0		13.00
14.00	Speech/ Language Pathology	0	0		14.00
15.00	Medical Social Services	0	0		15.00
16.00	Spiritual Counseling	0	0		16.00
17.00	Dietary Counseling	0	0		17.00
18.00	Counseling - Other	0	0		18.00
19.00	Home Health Aide and Homemaker	0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.00
21.00	Other	0	0		21.00
	OTHER HOSPICE SERVICE COSTS				
22.00	Drugs, Biological and Infusion Therapy	0	0		22.00
23.00	Analgesics	0	0		23.00
24.00	Sedatives / Hypnotics	0	0		24.00
25.00	Other - Specify	0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0	0		26.00
27.00	Patient Transportation	0	0		27.00
28.00	Imaging Services	0	0		28.00
29.00	Labs and Diagnostics	0	0		29.00
30.00	Medical Supplies	0	0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		31.00
32.00	Radiation Therapy	0	0		32.00
33.00	Chemotherapy	0	0		33.00
34.00	Other	0	0		34.00
	HOSPICE NONREIMBURSABLE SERVICE				
35.00	Bereavement Program Costs	0	0		35.00
36.00	Volunteer Program Costs	0	0		36.00
37.00	Fundraising	0	0		37.00
38.00	Other Program Costs	0	0		38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		0		39.00
40.00	Unit Cost Multiplier		0.000000		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-5 Part I Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS				
			BLDG & FIXT	NEW CARDIAC REHAB	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	1.01	2.00	4.00	
1.00	Administrative and General		0	0	0	29,035	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	156,020	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	156,020	0	0	0	29,035	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part I
Date/Time Prepared:
11/20/2015 10:22 am

Hospice I

	Cost Center Description	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		4A	5.00	7.00	8.00	9.00	
1.00	Administrative and General	29,035	7,346	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	156,020	39,474	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	185,055	46,820	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)	0.000000					35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part I
Date/Time Prepared:
11/20/2015 10:22 am

Hospice I

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	14,925	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	4,791	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	14,925	0	4,791	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-5 Part I Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

	Cost Center Description	MEDICAL RECORDS & LIBRARY	NURSING SCHOOL	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	
		16.00	20.00	24.00	25.00	26.00	
1.00	Administrative and General	0	29,724	66,105			1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	210,419	0	210,419	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	4,791	0	4,791	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	29,724	281,315	0	281,315	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-5 Part I Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

	Cost Center Description	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)		
		27.00	28.00		
1.00	Administrative and General				1.00
2.00	Inpatient - General Care	0	0		2.00
3.00	Inpatient - Respite Care	0	0		3.00
4.00	Physician Services	0	0		4.00
5.00	Nursing Care	64,633	275,052		5.00
6.00	Nursing Care-Continuous Home Care	0	0		6.00
7.00	Physical Therapy	0	0		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech/ Language Pathology	0	0		9.00
10.00	Medical Social Services	0	0		10.00
11.00	Spiritual Counseling	0	0		11.00
12.00	Dietary Counseling	0	0		12.00
13.00	Counseling - Other	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		15.00
16.00	Other	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	1,472	6,263		17.00
18.00	Analgesics	0	0		18.00
19.00	Sedatives / Hypnotics	0	0		19.00
20.00	Other - Specify	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0		21.00
22.00	Patient Transportation	0	0		22.00
23.00	Imaging Services	0	0		23.00
24.00	Labs and Diagnostics	0	0		24.00
25.00	Medical Supplies	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		26.00
27.00	Radiation Therapy	0	0		27.00
28.00	Chemotherapy	0	0		28.00
29.00	Other	0	0		29.00
30.00	Bereavement Program Costs	0	0		30.00
31.00	Volunteer Program Costs	0	0		31.00
32.00	Fundraising	0	0		32.00
33.00	Other Program Costs	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)		281,315		34.00
35.00	Unit Cost Multiplier (see instructions)	0.307165			35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part II
Date/Time Prepared:
11/20/2015 10:22 am

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		BLDG & FIXT (SQUARE FEET)	NEW CARDIAC REHAB (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIE)	Reconciliation	
		1.00	1.01	2.00	4.00	5A	
1.00	Administrative and General	0	0	8,333	272,685	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	8,333	272,685		34.00
35.00	Total cost to be allocated	0	0	0	29,035		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	0.106478		36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part II
Date/Time Prepared:
11/20/2015 10:22 am

Hospice I

	Cost Center Description	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	29,035	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	156,020	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	185,055	0	0	0	0	34.00
35.00	Total cost to be allocated	46,820	0	0	0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.253006	0.000000	0.000000	0.000000	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part II
Date/Time Prepared:
11/20/2015 10:22 am

Hospice I

	Cost Center Description	CAFETERIA (FTES)	NURSING ADMINISTRATION (FTES)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	0	0	0	0	0	2.00
3.00	Inpatient - Respite Care	0	0	0	0	0	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	0	259	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	285	99,995	0	17.00
18.00	Analgesics	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	Imaging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28.00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundraising	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	259	285	99,995	0	34.00
35.00	Total cost to be allocated	0	14,925	0	4,791	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	57.625483	0.000000	0.047912	0.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140001
Hospice CCN: 141558

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

Worksheet K-5
Part II
Date/Time Prepared:
11/20/2015 10:22 am

Hospice I

	Cost Center Description	NURSING SCHOOL (ASSIGNED TIME)		
		20.00		
1.00	Administrative and General	19,000		1.00
2.00	Inpatient - General Care	0		2.00
3.00	Inpatient - Respite Care	0		3.00
4.00	Physician Services	0		4.00
5.00	Nursing Care	0		5.00
6.00	Nursing Care-Continuous Home Care	0		6.00
7.00	Physical Therapy	0		7.00
8.00	Occupational Therapy	0		8.00
9.00	Speech/ Language Pathology	0		9.00
10.00	Medical Social Services	0		10.00
11.00	Spiritual Counseling	0		11.00
12.00	Dietary Counseling	0		12.00
13.00	Counseling - Other	0		13.00
14.00	Home Health Aide and Homemaker	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		15.00
16.00	Other	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0		17.00
18.00	Analgesics	0		18.00
19.00	Sedatives / Hypnotics	0		19.00
20.00	Other - Specify	0		20.00
21.00	Durable Medical Equipment/Oxygen	0		21.00
22.00	Patient Transportation	0		22.00
23.00	Imaging Services	0		23.00
24.00	Labs and Diagnostics	0		24.00
25.00	Medical Supplies	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0		26.00
27.00	Radiation Therapy	0		27.00
28.00	Chemotherapy	0		28.00
29.00	Other	0		29.00
30.00	Bereavement Program Costs	0		30.00
31.00	Volunteer Program Costs	0		31.00
32.00	Fundraising	0		32.00
33.00	Other Program Costs	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	19,000		34.00
35.00	Total cost to be allocated	29,724		35.00
36.00	Unit Cost Multiplier (see instructions)	1.564421		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-5 Part III Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

	Cost Center Description	Wkst. C, Part I, col. 11 line	Cost to Charge Ratio	Total Hospice Charges (Provider Records)	Hospice Shared Ancillary Costs (cols. 1 x 2)	
		0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS					
1.00	PHYSICAL THERAPY	66.00	0.323292	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00				2.00
3.00	SPEECH PATHOLOGY	68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.387571	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0.526971	0	0	5.00
6.00	LABORATORY	60.00	0.202422	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.233973	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00				9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS	76.00				10.00
10.97	CARDIAC REHABILITATION	76.97	0.785800	0	0	10.97
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140001 Hospice CCN: 141558

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

Worksheet K-6

Date/Time Prepared: 11/20/2015 10:22 am

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				281,315	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				1,309	2.00
3.00	Average cost per diem (line 1 divided by line 2)				214.91	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	1,272				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	273,366				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		15			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		3,224			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		0			10.00
11.00	Aggregate NF cost (line 3 times line 10)		0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			22		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			4,728		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140001	Period: From 07/01/2014 To 06/30/2015	Worksheet L Parts I-III Date/Time Prepared: 11/20/2015 10:22 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	416,738	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	8,499	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	19.92	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	425,237	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00

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

Provider CCN: 140001 Component CCN: 143493 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/20/2015 10:22 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	34,777	0	34,777	-601	34,176	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	2,059,938	0	2,059,938	-115,797	1,944,141	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	1,112,679	0	1,112,679	-59,859	1,052,820	9.00
10.00	Subtotal (sum of lines 1 through 9)	3,207,394	0	3,207,394	-176,257	3,031,137	10.00
11.00	Physician Services Under Agreement	0	8,677,870	8,677,870	-1,854,812	6,823,058	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	8,677,870	8,677,870	-1,854,812	6,823,058	14.00
15.00	Medical Supplies	0	176,812	176,812	-3,053	173,759	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	29,622	29,622	-512	29,110	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	206,434	206,434	-3,565	202,869	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	3,207,394	8,884,304	12,091,698	-2,034,634	10,057,064	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	5,868	5,868	-101	5,767	29.00
30.00	Administrative Costs	30,794	134,653	165,447	-2,595	162,852	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	30,794	140,521	171,315	-2,696	168,619	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,238,188	9,024,825	12,263,013	-2,037,330	10,225,683	32.00

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

Provider CCN: 140001 | Component CCN: 143493 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/20/2015 10:22 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	34,176		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	1,944,141		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	1,052,820		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	3,031,137		10.00
11.00	Physician Services Under Agreement	0	6,823,058		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	6,823,058		14.00
15.00	Medical Supplies	0	173,759		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	29,110		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	202,869		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	10,057,064		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	-5,481	286		29.00
30.00	Administrative Costs	-49,797	113,055		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-55,278	113,341		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-55,278	10,170,405		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140001 | Component CCN: 143493 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-2 | Date/Time Prepared: 11/20/2015 10:22 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	15.38	72,845	4,200	64,596		1.00
2.00	Physician Assistant	2.50	8,975	2,100	5,250		2.00
3.00	Nurse Practitioner	3.80	10,267	2,100	7,980		3.00
4.00	Subtotal (sum of lines 1 through 3)	21.68	92,087		77,826	92,087	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	21.68	92,087			92,087	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					10,057,064	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					10,057,064	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					113,341	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					5,202,330	15.00
16.00	Total overhead (sum of lines 14 and 15)					5,315,671	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					5,315,671	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					5,315,671	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					15,372,735	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 140001 | Component CCN: 143493 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-3 | Date/Time Prepared: 11/20/2015 10:22 am

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		15,372,735	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		164,672	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		15,208,063	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		92,087	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		92,087	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		165.15	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	165.15	165.15	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	4,242	13,087	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	700,566	2,161,318	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		2,861,884	16.00
16.01	Total program charges (see instructions)(from contractor's records)		2,708,336	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		29,905	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		31,601	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		2,100,046	16.04
16.05	Total program cost (see instructions)		2,131,647	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		205,226	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		494,635	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		2,131,647	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		36,942	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		2,168,589	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		2,168,589	26.00
26.01	Sequestration adjustment (see instructions)		43,372	26.01
27.00	Interim payments		2,156,311	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		-31,094	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 140001 | Component CCN: 143493 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-4 | Date/Time Prepared: 11/20/2015 10:22 am

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	3,031,137	3,031,137	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.007191	0.009285	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	21,797	28,144	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	48,131	9,658	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	69,928	37,802	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	10,057,064	10,057,064	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	5,315,671	5,315,671	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.006953	0.003759	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	36,960	19,982	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	106,888	57,784	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1,954	2,523	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	54.70	22.90	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	389	684	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	21,278	15,664	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		164,672	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		36,942	16.00

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

Provider CCN: 140001 Component CCN: 143493

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

Worksheet M-5

Date/Time Prepared: 11/20/2015 10:22 am

Rural Health Clinic (RHC) I

Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		1,991,233	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		02/19/2015	115,348	3.01
3.02		06/18/2015	49,730	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		165,078	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		2,156,311	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		31,094	6.02
7.00	Total Medicare program liability (see instructions)		2,125,217	7.00

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