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: 140189	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/17/2015 3:15 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/17/2015 Time: 3:15 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 SARAH BUSH LINCOLN HEALTH CENTER (140189) 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	103,880	101,118	484,346	0	1.00
2.00	Subprovider - IPF	0	71,302	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
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		1,500		0	10.00
10.01	RURAL HEALTH CLINIC II	0		1,018		0	10.01
10.02	RURAL HEALTH CLINIC III	0		1,726		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		711		0	10.03
200.00	Total	0	175,182	106,073	484,346	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/17/2015 3:13 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1000 HEALTH CENTER DRIVE	PO Box: 372			1.00
2.00	City: MATTOON	State: IL	Zip Code: 61920-	County: COLES	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	SARAH BUSH LINCOLN HEALTH CENTER	140189	99914	1	05/01/1977	N	P	O	3.00
4.00	Subprovider - IPF	SARAH BUSH LINCOLN HEALTH CENTER	14S189	99914	4	01/01/1990	N	P	O	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									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	LINCOLNLAND HOME CARE OF SBLHS	147594	99914		06/18/1996	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice	LINCOLNLAND HOSPICE OF SBLHS	141599	99914		08/10/1999				14.00
15.00	Hospital-Based Health Clinic - RHC	CASEY RHC	143978	99914		06/15/1992	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	SULLIVAN RHC	143998	99914		01/13/1995	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	NEOGA RHC	143435	99914		05/31/1997	N	O	N	15.02
15.03	Hospital-Based Health Clinic - RHC IV	NEWTON RHC	148541	99914		07/01/2014	N	O	N	15.03
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2014	06/30/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	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.	1	N	23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/17/2015 3:13 pm

		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.	4,548	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

		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)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	Y	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.				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/17/2015 3:13 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/17/2015 3:13 pm

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

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

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

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

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	5,591,720	0	0	118.01

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

		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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/17/2015 3:13 pm

		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)						0.25	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: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/17/2015 3:13 pm

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	09/30/2015	Y	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)		N		N	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: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/17/2015 3:13 pm

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BARB	IPPOLITO	41.00
42.00	Enter the employer/company name of the cost report preparer.	SARAH BUSH LINCOLN HEALTH CENTER		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-258-2509	BIPPOLITO@SBLHS.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/17/2015 3:13 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	09/30/2015			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)				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.		REIMB. ACCOUNTANT		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/17/2015 3:13 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	77	28,105	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)		77	28,105	0.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT	32.00	9	3,285	0.00	0	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)		86	31,390	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY	45.00	0	0		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	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.03	RURAL HEALTH CLINIC IV	88.03				0	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		106				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: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/17/2015 3:13 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	10,518	3,298	19,721			1.00
2.00	HMO and other (see instructions)	2,078	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	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)	10,518	3,298	19,721			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT	1,253	280	2,193			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		701	1,358			13.00
14.00	Total (see instructions)	11,771	4,279	23,272	0.00	1,610.02	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	926	1,968	3,692	0.00	24.07	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	21,663	0	31,654	0.00	55.67	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	26.20	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	637	0	2,691	0.00	4.54	26.00
26.01	RURAL HEALTH CLINIC II	873	0	4,152	0.00	6.25	26.01
26.02	RURAL HEALTH CLINIC III	1,476	0	6,332	0.00	7.27	26.02
26.03	RURAL HEALTH CLINIC IV	792	0	3,114	0.00	3.79	26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	1,737.81	27.00
28.00	Observation Bed Days		1,107	5,043			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	269	556			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: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/17/2015 3:13 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,904	1,265	6,455	1.00
2.00	HMO and other (see instructions)			471	18		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	2,904	1,265	6,455	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	186	486	880	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						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	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.03	RURAL HEALTH CLINIC IV	0.00					26.03
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 11/17/2015 3:13 pm

		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	122,773,790	0	122,773,790	3,614,940.00	33.96	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		1,752,509	0	1,752,509	18,465.00	94.91	3.00
4.00	Physician-Part A - Administrative		683,786	0	683,786	2,789.00	245.17	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		13,864,033	0	13,864,033	67,689.00	204.82	5.00
6.00	Non-physician-Part B		565,093	0	565,093	7,909.00	71.45	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		42,127,486	0	42,127,486	1,067,322.00	39.47	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		38,120	0	38,120	331.00	115.17	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)		31,415,287	0	31,415,287			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		7,415,258	0	7,415,258			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		416,238	0	416,238			21.00
22.00	Physician Part A - Administrative		92,983	0	92,983			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		2,045,081	0	2,045,081			23.00
24.00	Wage-related costs (RHC/FQHC)		86,126	0	86,126			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	662,098	0	662,098	19,716.00	33.58	26.00
27.00	Administrative & General	5.00	13,714,032	0	13,714,032	390,890.00	35.08	27.00
28.00	Administrative & General under contract (see inst.)		319,581	0	319,581	1,219.00	262.17	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,120,491	0	1,120,491	49,030.00	22.85	30.00
31.00	Laundry & Linen Service	8.00	28,480	0	28,480	2,233.00	12.75	31.00
32.00	Housekeeping	9.00	1,417,570	0	1,417,570	100,451.00	14.11	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,416,729	-1,008,428	408,301	27,422.00	14.89	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,008,428	1,008,428	67,727.00	14.89	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,729,533	0	1,729,533	52,394.00	33.01	38.00
39.00	Central Services and Supply	14.00	483,945	0	483,945	28,895.00	16.75	39.00
40.00	Pharmacy	15.00	1,566,672	0	1,566,672	43,312.00	36.17	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 11/17/2015 3:13 pm

		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	
41.00	Medical Records & Medical Records Library	16.00	1,549,360	0	1,549,360	127,967.00	12.11	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: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 11/17/2015 3:13 pm

		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)		106,911,736	0	106,911,736	3,522,096.00	30.35	1.00
2.00	Excluded area salaries (see instructions)		42,127,486	0	42,127,486	1,067,322.00	39.47	2.00
3.00	Subtotal salaries (line 1 minus line 2)		64,784,250	0	64,784,250	2,454,774.00	26.39	3.00
4.00	Subtotal other wages & related costs (see inst.)		38,120	0	38,120	331.00	115.17	4.00
5.00	Subtotal wage-related costs (see inst.)		31,508,270	0	31,508,270	0.00	48.64	5.00
6.00	Total (sum of lines 3 thru 5)		96,330,640	0	96,330,640	2,455,105.00	39.24	6.00
7.00	Total overhead cost (see instructions)		24,008,491	0	24,008,491	911,256.00	26.35	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part IV Date/Time Prepared: 11/17/2015 3:13 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	4,940,549	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	662,736	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	15,906,784	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	747,580	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	272,226	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	33,707	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	301,869	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,685,437	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	6,654,141	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	61,791	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	0	22.00
23.00	Tuition Reimbursement	148,467	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	31,415,287	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 11/17/2015 3:13 pm

	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	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	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			8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	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
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
14.02	Hospital-Based Health Clinic RHC 2	0	0	14.02
14.03	Hospital-Based Health Clinic RHC 3	0	0	14.03
15.00	Hospital-Based Health Clinic FQHC			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: 140189 | Component CCN: 147594 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-4 | Date/Time Prepared: 11/17/2015 3:13 pm

Home Health Agency I | PPS

						1.00	
0.00	County				COLES		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	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1,042.00	158.00	571.00	1,771.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.48	0.00	0.48	3.00
4.00	Director(s) and Assistant Director(s)			2.05	0.00	2.05	4.00
5.00	Other Administrative Personnel			12.44	0.00	12.44	5.00
6.00	Direct Nursing Service			27.13	0.00	27.13	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			6.29	0.00	6.29	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			2.64	0.00	2.64	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.69	0.00	0.69	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.55	0.00	0.55	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			3.40	0.00	3.40	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			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
		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	11,808	1,106	514	382	13,810	21.00
22.00	Skilled Nursing Visit Charges	1,889,029	186,452	68,466	62,281	2,206,228	22.00
23.00	Physical Therapy Visits	3,469	46	78	74	3,667	23.00
24.00	Physical Therapy Visit Charges	636,954	8,372	14,320	13,652	673,298	24.00
25.00	Occupational Therapy Visits	1,209	20	25	52	1,306	25.00
26.00	Occupational Therapy Visit Charges	220,047	3,640	4,429	9,464	237,580	26.00
27.00	Speech Pathology Visits	152	0	6	0	158	27.00
28.00	Speech Pathology Visit Charges	27,969	0	2,065	0	30,034	28.00
29.00	Medical Social Service Visits	148	4	3	5	160	29.00
30.00	Medical Social Service Visit Charges	33,004	892	669	1,115	35,680	30.00
31.00	Home Health Aide Visits	2,375	160	8	19	2,562	31.00
32.00	Home Health Aide Visit Charges	182,052	12,246	546	1,482	196,326	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	19,161	1,336	634	532	21,663	33.00
34.00	Other Charges	96,242	13,948	4,846	2,165	117,201	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3,085,297	225,550	95,341	90,159	3,496,347	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,393		33	0	1,426	36.00
37.00	Total Number of Outlier Episodes		33		0	33	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

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

Provider CCN: 140189
Component CCN: 143978

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

Worksheet S-8

Date/Time Prepared:
11/17/2015 3:13 pm

		Rural Health Clinic (RHC) I	Cost	
		1.00		
	Clinic Address and Identification			
1.00	Street	412 NW 3RD		1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	CASEY	IL	62420 2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

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

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

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

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

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

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

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

Provider CCN: 140189
Component CCN: 143978

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

Worksheet S-8

Date/Time Prepared:
11/17/2015 3:13 pm

Rural Health Clinic (RHC) I

Cost

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

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

Provider CCN: 140189
Component CCN: 143998

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

Worksheet S-8

Date/Time Prepared:
11/17/2015 3:13 pm

		Rural Health Clinic (RHC) II	Cost	
		1.00		
	Clinic Address and Identification			
1.00	Street	7 HAWTHORNE LANE		1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	SULLIVAN	IL	61951 2.00
			1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

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

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

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

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

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

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

Provider CCN: 140189
Component CCN: 143998

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

Worksheet S-8

Date/Time Prepared:
11/17/2015 3:13 pm

Rural Health Clinic (RHC) II

Cost

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

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

Provider CCN: 140189
Component CCN: 143435

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

Worksheet S-8

Date/Time Prepared:
11/17/2015 3:13 pm

		Rural Health Clinic (RHC) III	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	650 OAK AVENUE	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	NEOGA	IL	62447	2.00

		1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	0	3.00

		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00

		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

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

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

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

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

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

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

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

Provider CCN: 140189
Component CCN: 143435

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

Worksheet S-8

Date/Time Prepared:
11/17/2015 3:13 pm

Rural Health Clinic (RHC) III

Cost

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

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

Provider CCN: 140189
Component CCN: 148541

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

Worksheet S-8

Date/Time Prepared:
11/17/2015 3:13 pm

		Rural Health Clinic (RHC) IV	Cost	
		1.00		
	Clinic Address and Identification			
1.00	Street	910 SOUTH VAN BUREN ST		1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	NEWTON	IL	62448 2.00
				1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0	3.00
		Grant Award	Date	
		1.00	2.00	
	Source of Federal Funds			
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0	10.00

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

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

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

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

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

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

Provider CCN: 140189
Component CCN: 148541

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

Worksheet S-8

Date/Time Prepared:
11/17/2015 3:13 pm

Rural Health Clinic (RHC) IV

Cost

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

HOSPITAL IDENTIFICATION DATA | Provider CCN: 140189 Component CCN: 141599 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-9 Parts I & II Date/Time Prepared: 11/17/2015 3:13 pm

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	18,220	1,747	9,315	931	1,479	21,446	2.00
3.00	Inpatient Respite Care	34	1	34	1	0	35	3.00
4.00	General Inpatient Care	86	2	86	2	4	92	4.00
5.00	Total Hospice Days	18,340	1,750	9,435	934	1,483	21,573	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving Hospice Care	585	32	373	18	48	665	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)	31.35	54.69	25.29	51.89	30.90	32.44	8.00
9.00	Unduplicated Census Count	562	30	343	17	47	639	9.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 11/17/2015 3:13 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.252268	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	8,737,619	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	7,963,105	5.00
6.00	Medicaid charges	118,193,395	6.00
7.00	Medicaid cost (line 1 times line 6)	29,816,411	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)	13,115,687	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)	13,115,687	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	2,349,472	10,114,828	12,464,300	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	592,697	2,551,647	3,144,344	21.00
22.00	Partial payment by patients approved for charity care	51,934	1,763,446	1,815,380	22.00
23.00	Cost of charity care (line 21 minus line 22)	540,763	788,201	1,328,964	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)	6,271,864	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	1,129,741	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	5,142,123	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,297,193	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,626,157	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	15,741,844	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/17/2015 3:13 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		0	0	6,228,040	6,228,040	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		0	0	8,401,962	8,401,962	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	662,098	24,818,785	25,480,883	219,031	25,699,914	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,714,032	34,413,787	48,127,819	-16,122,487	32,005,332	5.00
7.00	00700	OPERATION OF PLANT	1,120,491	3,379,194	4,499,685	-30,688	4,468,997	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	28,480	595,462	623,942	0	623,942	8.00
9.00	00900	HOUSEKEEPING	1,417,570	394,312	1,811,882	0	1,811,882	9.00
10.00	01000	DIETARY	1,416,729	1,155,507	2,572,236	-1,830,918	741,318	10.00
11.00	01100	CAFETERIA	0	0	0	1,830,918	1,830,918	11.00
13.00	01300	NURSING ADMINISTRATION	1,729,533	233,329	1,962,862	-8,889	1,953,973	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	483,945	898,315	1,382,260	-36,617	1,345,643	14.00
15.00	01500	PHARMACY	1,566,672	11,277,260	12,843,932	-11,006,298	1,837,634	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,549,360	920,507	2,469,867	-6,532	2,463,335	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	13,464,727	2,198,162	15,662,889	-1,111,296	14,551,593	30.00
32.00	03200	CORONARY CARE UNIT	1,543,495	554,653	2,098,148	-1,196	2,096,952	32.00
40.00	04000	SUBPROVIDER - IPF	2,978,890	258,479	3,237,369	14,217	3,251,586	40.00
43.00	04300	NURSERY	0	34,436	34,436	473,069	507,505	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,506,663	1,924,079	6,430,742	-80,763	6,349,979	50.00
51.00	05100	RECOVERY ROOM	1,411,438	318,493	1,729,931	-8,218	1,721,713	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	82,421	82,421	719,504	801,925	52.00
53.00	05300	ANESTHESIOLOGY	5,466,986	656,975	6,123,961	519,262	6,643,223	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,765,021	1,289,803	7,054,824	-402,575	6,652,249	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,145,094	402,299	2,547,393	30,351	2,577,744	55.00
56.00	05600	RADIOISOTOPE	962,503	1,209,278	2,171,781	230,015	2,401,796	56.00
57.00	05700	CT SCAN	358,619	688,632	1,047,251	85,725	1,132,976	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	267,121	528,192	795,313	68,537	863,850	58.00
59.00	05900	CARDIAC CATHETERIZATION	550,242	360,627	910,869	-7,440	903,429	59.00
60.00	06000	LABORATORY	4,730,368	4,906,167	9,636,535	11,138	9,647,673	60.00
65.00	06500	RESPIRATORY THERAPY	936,376	340,586	1,276,962	-2,382	1,274,580	65.00
66.00	06600	PHYSICAL THERAPY	1,769,427	787,734	2,557,161	-19,300	2,537,861	66.00
67.00	06700	OCCUPATIONAL THERAPY	387,966	53,275	441,241	0	441,241	67.00
68.00	06800	SPEECH PATHOLOGY	790,496	542,168	1,332,664	-759	1,331,905	68.00
69.00	06900	ELECTROCARDIOLOGY	1,149,787	2,702,076	3,851,863	894	3,852,757	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	865,929	1,012,436	1,878,365	-10,315	1,868,050	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,055,355	4,055,355	0	4,055,355	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	5,937,165	5,937,165	0	5,937,165	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,857,526	10,857,526	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	522,615	48,516	571,131	-25,648	545,483	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	252,229	94,727	346,956	10,966	357,922	88.00
88.01	08801	RURAL HEALTH CLINIC II	475,303	137,529	612,832	24,433	637,265	88.01
88.02	08802	RURAL HEALTH CLINIC III	671,961	104,011	775,972	24,569	800,541	88.02
88.03	08803	RURAL HEALTH CLINIC IV	226,633	139,014	365,647	10,809	376,456	88.03
91.00	09100	EMERGENCY	7,736,395	2,723,564	10,459,959	276,691	10,736,650	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,359,866	794,310	4,154,176	-10,139	4,144,037	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,374,448	1,123,913	2,498,361	-189,268	2,309,093	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	88,359,508	114,095,533	202,455,041	-874,071	201,580,970	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	30,843,759	8,264,277	39,108,036	1,089,079	40,197,115	192.00
194.00	07950	WELLNESS	637,351	531,853	1,169,204	-6,473	1,162,731	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	1,102,223	1,563,043	2,665,266	-3,219	2,662,047	194.01
194.02	07951	LIFELINE	26,730	116,363	143,093	0	143,093	194.02
194.03	07952	OCCUPATIONAL HEALTH	337,390	135,716	473,106	-202,616	270,490	194.03
194.05	07954	MISC. NONREIMBURSABLE	1,466,829	540,451	2,007,280	-2,700	2,004,580	194.05
200.00		TOTAL (SUM OF LINES 118-199)	122,773,790	125,247,236	248,021,026	0	248,021,026	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/17/2015 3:13 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-1,273,508	4,954,532		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	0	8,401,962		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-325,124	25,374,790		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,841,378	27,163,954		5.00
7.00	00700	OPERATION OF PLANT	-1,155	4,467,842		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	623,942		8.00
9.00	00900	HOUSEKEEPING	-3,175	1,808,707		9.00
10.00	01000	DIETARY	-1,494	739,824		10.00
11.00	01100	CAFETERIA	-829,847	1,001,071		11.00
13.00	01300	NURSING ADMINISTRATION	0	1,953,973		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,345,643		14.00
15.00	01500	PHARMACY	0	1,837,634		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-94,981	2,368,354		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-3,445,907	11,105,686		30.00
32.00	03200	CORONARY CARE UNIT	-30,000	2,066,952		32.00
40.00	04000	SUBPROVIDER - IPF	-1,820,823	1,430,763		40.00
43.00	04300	NURSERY	0	507,505		43.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	6,349,979		50.00
51.00	05100	RECOVERY ROOM	0	1,721,713		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	801,925		52.00
53.00	05300	ANESTHESIOLOGY	-5,986,187	657,036		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,871,460	4,780,789		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-1,288,067	1,289,677		55.00
56.00	05600	RADIOISOTOPE	0	2,401,796		56.00
57.00	05700	CT SCAN	0	1,132,976		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	863,850		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	903,429		59.00
60.00	06000	LABORATORY	-831,344	8,816,329		60.00
65.00	06500	RESPIRATORY THERAPY	0	1,274,580		65.00
66.00	06600	PHYSICAL THERAPY	-6,019	2,531,842		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	441,241		67.00
68.00	06800	SPEECH PATHOLOGY	-845,507	486,398		68.00
69.00	06900	ELECTROCARDIOLOGY	-2,599,441	1,253,316		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-697,199	1,170,851		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,055,355		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	5,937,165		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,857,526		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	545,483		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	357,922		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	637,265		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	800,541		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	376,456		88.03
91.00	09100	EMERGENCY	-5,831,542	4,905,108		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	4,144,037		101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	2,309,093		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-32,624,158	168,956,812		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	40,197,115		192.00
194.00	07950	WELLNESS	0	1,162,731		194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	2,662,047		194.01
194.02	07951	LIFELINE	0	143,093		194.02
194.03	07952	OCCUPATIONAL HEALTH	0	270,490		194.03
194.05	07954	MISC. NONREIMBURSABLE	0	2,004,580		194.05
200.00		TOTAL (SUM OF LINES 118-199)	-32,624,158	215,396,868		200.00

RECLASSIFICATIONS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/17/2015 3:13 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	10,857,526	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
	TOTALS		0	10,857,526	
	B - RADIOLOGY ADMIN EXPENSE ALLOCATION				
1.00	RADIOISOTOPE	56.00	200,490	29,525	1.00
2.00	CT SCAN	57.00	74,700	16,813	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	55,641	12,896	3.00
	TOTALS		330,831	59,234	
	C - CAP REL COSTS-MOVABLE EQUIP				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	742,990	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
34.00		0.00	0	0	34.00
	TOTALS		0	742,990	
	D - DEPRECIATION				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	4,761,166	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	7,658,972	2.00
	TOTALS		0	12,420,138	
	E - CAFETERIA EXPENSE				
1.00	CAFETERIA	11.00	1,008,428	822,490	1.00
	TOTALS		1,008,428	822,490	
	F - EMPLOYEE PHYSICALS/BENF EXP				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	200,425	1.00
	TOTALS		0	200,425	
	G - EAP BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	25,648	1.00
	TOTALS		0	25,648	
	H - INTEREST EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,466,874	1.00
	TOTALS		0	1,466,874	
	I - NURSRY/L&D EXP				
1.00	NURSERY	43.00	474,119	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	719,504	0	2.00
	TOTALS		1,193,623	0	

RECLASSIFICATIONS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/17/2015 3:13 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	J - PHYSN PROF LIAB EXP				
1.00	ADULTS & PEDIATRICS	30.00	0	100,884	1.00
2.00	SUBPROVIDER - IPF	40.00	0	18,015	2.00
3.00	ANESTHESIOLOGY	53.00	0	522,436	3.00
4.00	RADIOLOGY-THERAPEUTIC	55.00	0	32,427	4.00
5.00	LABORATORY	60.00	0	14,412	5.00
6.00	ELECTROCARDIOLOGY	69.00	0	7,206	6.00
7.00	EMERGENCY	91.00	0	284,637	7.00
8.00	RURAL HEALTH CLINIC	88.00	0	11,809	8.00
9.00	RURAL HEALTH CLINIC II	88.01	0	25,221	9.00
10.00	RURAL HEALTH CLINIC III	88.02	0	25,221	10.00
11.00	RURAL HEALTH CLINIC IV	88.03	0	10,809	11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,137,544	12.00
	TOTALS		0	2,190,621	
500.00	Grand Total: Increases		2,532,882	28,785,946	500.00

RECLASSIFICATIONS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/17/2015 3:13 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	10,841,309	0		1.00
2.00	RECOVERY ROOM	51.00	0	7,103	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	3,086	0		3.00
4.00	PHYSICAL THERAPY	66.00	0	150	0		4.00
5.00	EMERGENCY	91.00	0	90	0		5.00
6.00	CT SCAN	57.00	0	5,788	0		6.00
	TOTALS		0	10,857,526			
	B - RADIOLOGY ADMIN EXPENSE ALLOCATION						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	330,831	59,234	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		330,831	59,234			
	C - CAP REL COSTS-MOVABLE EQUIP						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7,042	14		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	44,854	14		2.00
3.00	OPERATION OF PLANT	7.00	0	30,688	14		3.00
4.00	NURSING ADMINISTRATION	13.00	0	8,889	14		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	36,617	14		5.00
6.00	PHARMACY	15.00	0	164,989	14		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	6,532	14		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	18,557	14		8.00
9.00	CORONARY CARE UNIT	32.00	0	1,196	14		9.00
10.00	SUBPROVIDER - IPF	40.00	0	3,798	14		10.00
11.00	NURSERY	43.00	0	1,050	14		11.00
12.00	OPERATING ROOM	50.00	0	80,763	14		12.00
13.00	RECOVERY ROOM	51.00	0	1,115	14		13.00
14.00	ANESTHESIOLOGY	53.00	0	88	14		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	12,510	14		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,076	14		16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	7,440	14		17.00
18.00	LABORATORY	60.00	0	3,274	14		18.00
19.00	RESPIRATORY THERAPY	65.00	0	2,382	14		19.00
20.00	PHYSICAL THERAPY	66.00	0	19,150	14		20.00
21.00	SPEECH PATHOLOGY	68.00	0	759	14		21.00
22.00	ELECTROCARDIOLOGY	69.00	0	6,312	14		22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	10,315	14		23.00
24.00	RURAL HEALTH CLINIC	88.00	0	843	14		24.00
25.00	RURAL HEALTH CLINIC II	88.01	0	788	14		25.00
26.00	RURAL HEALTH CLINIC III	88.02	0	652	14		26.00
27.00	EMERGENCY	91.00	0	7,856	14		27.00
28.00	HOME HEALTH AGENCY	101.00	0	10,139	14		28.00
29.00	HOSPICE	116.00	0	189,268	14		29.00
30.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	48,465	14		30.00
31.00	WELLNESS	194.00	0	6,473	14		31.00
32.00	OCCUPATIONAL HEALTH	194.03	0	2,191	14		32.00
33.00	MISC. NONREIMBURSABLE	194.05	0	2,700	14		33.00
34.00	OTHER NONREIMB PROGRAM: PEACE MEAL	194.01	0	3,219	14		34.00
	TOTALS		0	742,990			
	D - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,420,138	9		1.00
2.00		0.00	0	0	9		2.00
	TOTALS		0	12,420,138			
	E - CAFETERIA EXPENSE						
1.00	DIETARY	10.00	1,008,428	822,490	0		1.00
	TOTALS		1,008,428	822,490			
	F - EMPLOYEE PHYSICALS/BENF EXP						
1.00	OCCUPATIONAL HEALTH	194.03	0	200,425	0		1.00
	TOTALS		0	200,425			
	G - EAP BENEFITS						
1.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	0	25,648	0		1.00
	TOTALS		0	25,648			
	H - INTEREST EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,466,874	11		1.00
	TOTALS		0	1,466,874			
	I - NURSRY/L&D EXP						
1.00	ADULTS & PEDIATRICS	30.00	1,193,623	0	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		1,193,623	0			

RECLASSIFICATIONS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/17/2015 3:13 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	J - PHYSN PROF LIAB EXP						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,190,621	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
	TOTALS		0	2,190,621			
500.00	Grand Total: Decreases		2,532,882	28,785,946			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 11/17/2015 3:13 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	3,265,418	216,914	0	216,914	76,586	1.00
2.00	Land Improvements	7,342,103	1,298,006	0	1,298,006	0	2.00
3.00	Buildings and Fixtures	107,924,239	26,006,726	0	26,006,726	2,325,362	3.00
4.00	Building Improvements	626,853	877	0	877	20,178	4.00
5.00	Fixed Equipment	13,530,387	2,913,653	0	2,913,653	163,456	5.00
6.00	Movable Equipment	83,285,666	9,196,447	0	9,196,447	16,000,777	6.00
7.00	HIT designated Assets	533,635	150,917	0	150,917	0	7.00
8.00	Subtotal (sum of lines 1-7)	216,508,301	39,783,540	0	39,783,540	18,586,359	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	216,508,301	39,783,540	0	39,783,540	18,586,359	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	3,405,746	0	1.00
2.00	Land Improvements	8,640,109	0	2.00
3.00	Buildings and Fixtures	131,605,603	0	3.00
4.00	Building Improvements	607,552	0	4.00
5.00	Fixed Equipment	16,280,584	0	5.00
6.00	Movable Equipment	76,481,336	0	6.00
7.00	HIT designated Assets	684,552	0	7.00
8.00	Subtotal (sum of lines 1-7)	237,705,482	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	237,705,482	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 11/17/2015 3:13 pm

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

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

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 11/17/2015 3:13 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	4,761,166	0	4,761,166	0.383342	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	7,658,972	0	7,658,972	0.616658	0	2.00
3.00	Total (sum of lines 1-2)	12,420,138	0	12,420,138	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	4,761,166	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	7,658,972	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,420,138	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	193,366	0	0	0	4,954,532	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	742,990	8,401,962	2.00
3.00	Total (sum of lines 1-2)	193,366	0	0	742,990	13,356,494	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/17/2015 3:13 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		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	-22,235,869			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	B	-829,847	CAFETERIA	11.00	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	B	-94,981	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-3,175	HOUSEKEEPING	9.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/17/2015 3:13 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	INVESTMENT INCOME	B	-1,273,508	NEW CAP REL COSTS-BLDG & FIXT	1.00	11	33.00
35.00	A&G OTHER INCOME	B	-249,319	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	DIETARY OUTREACH REVENUE	B	-1,494	DIETARY	10.00	0	36.00
37.00	FACILITIES SVC OTHER REV	B	-1,155	OPERATION OF PLANT	7.00	0	37.00
38.00	W&C (BABY CLASSES), 4W MISC	B	-13,621	ADULTS & PEDIATRICS	30.00	0	38.00
38.01	CCU MISC REV	B	-30,000	CORONARY CARE UNIT	32.00	0	38.01
39.00	XRAY OTHER REVENUE	B	-6,407	RADIOLOGY-DIAGNOSTIC	54.00	0	39.00
39.01	MED ONCOLOGY MISC REV	B	-2,589	RADIOLOGY-THERAPEUTIC	55.00	0	39.01
41.00	PHYSICAL THERAPY OTHER REV	B	-6,019	PHYSICAL THERAPY	66.00	0	41.00
42.00	MEDICAID ASSESSMENT TAX	A	-4,553,949	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	SPEECH/AUDIO OTHER REV	B	-845,507	SPEECH PATHOLOGY	68.00	0	43.00
44.00	CARDIOLOGY OTHER REV	B	-72,072	ELECTROCARDIOLOGY	69.00	0	44.00
45.00	EMERGENCY (EMS) OTHER REV	B	-159,669	EMERGENCY	91.00	0	45.00
45.01	AHA/IHA LOBBYING FEES	A	-38,110	ADMINISTRATIVE & GENERAL	5.00	0	45.01
45.02	CRNA S&W (EMPLOYEES & LOCUM TENENS)	A	-1,881,743	ANESTHESIOLOGY	53.00	0	45.02
45.03	CRNA (BENEFIT EXP)	A	-325,124	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-32,624,158				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: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 11/17/2015 3:13 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	3,432,286	3,432,286	0	142,500	0	1.00
2.00	40.00	SUBPROVIDER - IPF	1,820,823	1,820,823	0	138,700	0	2.00
3.00	53.00	ANESTHESIOLOGY	3,743,400	3,743,400	0	167,500	0	3.00
4.00	53.00	DR. A	502,317	160,913	341,404	167,500	1,430	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	1,865,053	1,865,053	0	217,600	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	1,285,478	1,285,478	0	217,600	0	6.00
7.00	60.00	DR. B	231,540	211,229	20,311	208,000	150	7.00
8.00	60.00	DR. C	633,600	582,268	51,332	208,000	169	8.00
9.00	69.00	ELECTROCARDIOLOGY	2,527,369	2,527,369	0	159,800	0	9.00
10.00	70.00	ELECTROENCEPHALOGRAPHY	697,199	697,199	0	159,800	0	10.00
11.00	91.00	EMERGENCY	5,217,577	5,217,577	0	159,800	0	11.00
12.00	91.00	DR. D	546,686	275,946	270,740	159,800	1,040	12.00
200.00			22,503,328	21,819,541	683,787		2,789	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	30.00	ADULTS & PEDIATRICS	0	0	51,442	0	100,884	1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	15,689	0	18,015	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	58,946	0	490,009	3.00
4.00	53.00	DR. A	115,156	5,758	6,000	4,078	32,427	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	21,655	0	0	5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	6,000	0	32,427	6.00
7.00	60.00	DR. B	15,000	750	1,769	155	7,206	7.00
8.00	60.00	DR. C	16,900	845	6,475	525	7,206	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	7,206	9.00
10.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	4,711	0	0	10.00
11.00	91.00	EMERGENCY	0	0	48,109	0	259,416	11.00
12.00	91.00	DR. D	79,900	3,995	0	0	25,221	12.00
200.00			226,956	11,348	220,796	4,758	980,017	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	30.00	ADULTS & PEDIATRICS	0	0	0	3,432,286		1.00
2.00	40.00	SUBPROVIDER - IPF	0	0	0	1,820,823		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	3,743,400		3.00
4.00	53.00	DR. A	22,039	141,273	200,131	361,044		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,865,053		5.00
6.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	1,285,478		6.00
7.00	60.00	DR. B	632	15,787	4,524	215,753		7.00
8.00	60.00	DR. C	584	18,009	33,323	615,591		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	2,527,369		9.00
10.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	697,199		10.00
11.00	91.00	EMERGENCY	0	0	0	5,217,577		11.00
12.00	91.00	DR. D	12,490	92,390	178,350	454,296		12.00
200.00			35,745	267,459	416,328	22,235,869		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/17/2015 3:13 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	4,954,532	4,954,532				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	8,401,962		8,401,962			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	25,374,790	40,629	3,792	25,419,211		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,163,954	711,598	2,123,743	2,854,768	32,854,063	5.00
7.00	00700	OPERATION OF PLANT	4,467,842	352,423	171,246	233,246	5,224,757	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	623,942	11,796	0	5,929	641,667	8.00
9.00	00900	HOUSEKEEPING	1,808,707	103,061	12,947	295,087	2,219,802	9.00
10.00	01000	DIETARY	739,824	72,906	55,599	84,994	953,323	10.00
11.00	01100	CAFETERIA	1,001,071	44,128	22,511	209,918	1,277,628	11.00
13.00	01300	NURSING ADMINISTRATION	1,953,973	15,739	2,689	360,027	2,332,428	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,345,643	70,851	158,309	100,740	1,675,543	14.00
15.00	01500	PHARMACY	1,837,634	32,599	24,928	326,125	2,221,286	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,368,354	35,364	140,346	322,521	2,866,585	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,105,686	371,982	381,489	2,554,402	14,413,559	30.00
32.00	03200	CORONARY CARE UNIT	2,066,952	49,226	177,021	321,300	2,614,499	32.00
40.00	04000	SUBPROVIDER - IPF	1,430,763	96,819	19,488	620,098	2,167,168	40.00
43.00	04300	NURSERY	507,505	6,853	15,265	98,695	628,318	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,349,979	388,542	1,063,161	938,125	8,739,807	50.00
51.00	05100	RECOVERY ROOM	1,721,713	17,471	9,758	293,811	2,042,753	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	801,925	15,627	97,884	149,775	1,065,211	52.00
53.00	05300	ANESTHESIOLOGY	657,036	7,175	81,922	1,138,030	1,884,163	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,780,789	150,343	620,629	1,131,203	6,682,964	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,289,677	75,994	83,346	446,531	1,895,548	55.00
56.00	05600	RADIOISOTOPE	2,401,796	21,636	741,860	242,093	3,407,385	56.00
57.00	05700	CT SCAN	1,132,976	16,949	158,740	90,201	1,398,866	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	863,850	22,691	399,059	67,187	1,352,787	58.00
59.00	05900	CARDIAC CATHETERIZATION	903,429	31,566	330,665	114,541	1,380,201	59.00
60.00	06000	LABORATORY	8,816,329	98,496	392,284	984,692	10,291,801	60.00
65.00	06500	RESPIRATORY THERAPY	1,274,580	17,160	63,872	194,920	1,550,532	65.00
66.00	06600	PHYSICAL THERAPY	2,531,842	159,695	46,513	368,331	3,106,381	66.00
67.00	06700	OCCUPATIONAL THERAPY	441,241	4,687	5,636	80,761	532,325	67.00
68.00	06800	SPEECH PATHOLOGY	486,398	34,365	21,331	164,553	706,647	68.00
69.00	06900	ELECTROCARDIOLOGY	1,253,316	63,676	88,118	239,344	1,644,454	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,170,851	50,992	50,935	180,255	1,453,033	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,055,355	0	0	0	4,055,355	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	5,937,165	0	0	0	5,937,165	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,857,526	0	0	0	10,857,526	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	545,483	30,200	3,571	108,790	688,044	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	357,922	158,207	7,708	52,505	576,342	88.00
88.01	08801	RURAL HEALTH CLINIC II	637,265	77,093	6,654	98,941	819,953	88.01
88.02	08802	RURAL HEALTH CLINIC III	800,541	31,444	8,352	139,878	980,215	88.02
88.03	08803	RURAL HEALTH CLINIC IV	376,456	0	16,234	47,177	439,867	88.03
91.00	09100	EMERGENCY	4,905,108	99,785	150,735	1,610,439	6,766,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	4,144,037	44,317	90,052	699,403	4,977,809	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	2,309,093	16,660	0	286,111	2,611,864	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	168,956,812	3,650,745	7,848,392	18,255,447	159,935,691	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	40,197,115	1,064,555	339,923	6,420,510	48,022,103	192.00
194.00	07950	WELLNESS	1,162,731	0	72,794	132,674	1,368,199	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	2,662,047	0	29,608	229,443	2,921,098	194.01
194.02	07951	LIFELINE	143,093	2,666	0	5,564	151,323	194.02
194.03	07952	OCCUPATIONAL HEALTH	270,490	32,332	9,241	70,232	382,295	194.03
194.05	07954	MISC. NONREIMBURSABLE	2,004,580	204,234	102,004	305,341	2,616,159	194.05
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)	215,396,868	4,954,532	8,401,962	25,419,211	215,396,868	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/17/2015 3:13 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	32,854,063					5.00
7.00	00700	OPERATION OF PLANT	940,352	6,165,109				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	115,487	16,839	773,993			8.00
9.00	00900	HOUSEKEEPING	399,520	147,127	30,390	2,796,839		9.00
10.00	01000	DIETARY	171,579	104,078	6,208	0	1,235,188	10.00
11.00	01100	CAFETERIA	229,947	62,996	0	132,499	0	11.00
13.00	01300	NURSING ADMINISTRATION	419,790	22,468	0	24,292	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	301,564	101,145	7,469	44,166	0	14.00
15.00	01500	PHARMACY	399,787	41,780	0	19,139	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	515,928	61,109	0	16,194	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,594,152	531,031	249,677	34,229	1,023,156	30.00
32.00	03200	CORONARY CARE UNIT	470,558	77,821	18,952	102,319	50,321	32.00
40.00	04000	SUBPROVIDER - IPF	390,047	138,216	16,612	113,360	133,398	40.00
43.00	04300	NURSERY	113,085	9,783	7,393	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,572,990	572,067	125,755	610,235	6,174	50.00
51.00	05100	RECOVERY ROOM	367,655	134,807	50,305	36,805	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	191,717	22,309	20,211	0	0	52.00
53.00	05300	ANESTHESIOLOGY	339,112	10,243	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,202,800	214,626	31,463	72,138	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	341,161	108,486	14,165	66,250	0	55.00
56.00	05600	RADIOISOTOPE	613,261	30,887	18,447	29,444	0	56.00
57.00	05700	CT SCAN	251,768	24,196	14,202	16,194	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	243,475	32,394	6,192	7,361	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	248,409	45,063	10,544	51,527	0	59.00
60.00	06000	LABORATORY	1,852,318	179,045	243	137,284	0	60.00
65.00	06500	RESPIRATORY THERAPY	279,065	24,497	0	18,771	0	65.00
66.00	06600	PHYSICAL THERAPY	559,086	227,977	10,420	117,777	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	95,808	6,691	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	127,182	49,058	193	2,208	0	68.00
69.00	06900	ELECTROCARDIOLOGY	295,969	90,902	7,710	107,840	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	261,517	72,795	730	50,055	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	729,883	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	1,068,571	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,954,138	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	123,834	43,112	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	103,730	225,852	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	147,575	110,056	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	176,419	44,888	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	79,167	28,033	0	0	0	88.03
91.00	09100	EMERGENCY	1,217,757	282,902	125,786	345,970	22,139	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	895,906	63,265	0	12,146	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	470,083	23,784	0	11,410	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,872,152	3,982,328	773,067	2,179,613	1,235,188	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,643,028	1,579,209	396	502,393	0	192.00
194.00	07950	WELLNESS	246,248	309,968	530	11,042	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	525,739	0	0	0	0	194.01
194.02	07951	LIFELINE	27,235	3,805	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	68,805	46,157	0	29,444	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	470,856	243,642	0	74,347	0	194.05
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)	32,854,063	6,165,109	773,993	2,796,839	1,235,188	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/17/2015 3:13 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	1,703,070					11.00
13.00	01300	NURSING ADMINISTRATION	39,350	2,838,328				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	22,036	0	2,151,923			14.00
15.00	01500	PHARMACY	33,054	0	0	2,715,046		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	58,238	0	0	0	3,518,054	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	322,672	1,248,506	0	0	170,757	30.00
32.00	03200	CORONARY CARE UNIT	37,776	157,446	0	0	23,451	32.00
40.00	04000	SUBPROVIDER - IPF	37,776	126,716	0	0	24,203	40.00
43.00	04300	NURSERY	14,166	62,827	0	0	12,027	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	129,068	540,367	0	0	388,468	50.00
51.00	05100	RECOVERY ROOM	36,202	147,628	0	0	97,669	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,888	90,983	0	0	31,267	52.00
53.00	05300	ANESTHESIOLOGY	29,906	11,877	0	0	69,331	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	58,238	0	0	0	167,687	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	34,628	0	0	0	71,357	55.00
56.00	05600	RADIOISOTOPE	17,314	0	0	0	187,152	56.00
57.00	05700	CT SCAN	11,018	0	0	0	302,059	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	7,870	0	0	0	132,763	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,592	0	0	0	97,286	59.00
60.00	06000	LABORATORY	141,660	0	0	0	280,896	60.00
65.00	06500	RESPIRATORY THERAPY	26,758	0	0	0	63,041	65.00
66.00	06600	PHYSICAL THERAPY	40,924	0	0	0	100,686	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,870	0	0	0	13,195	67.00
68.00	06800	SPEECH PATHOLOGY	17,314	0	0	0	15,136	68.00
69.00	06900	ELECTROCARDIOLOGY	34,628	0	0	0	45,185	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22,036	0	0	0	43,886	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	882,288	0	136,453	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	1,269,635	0	147,321	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,715,046	544,347	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	22,036	0	0	0	1,173	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	1,819	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	4,212	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	5,385	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	2,263	88.03
91.00	09100	EMERGENCY	125,920	451,978	0	0	268,775	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	18,888	0	0	0	32,488	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	4,722	0	0	0	36,316	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,383,548	2,838,328	2,151,923	2,715,046	3,518,054	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	267,580	0	0	0	0	192.00
194.00	07950	WELLNESS	26,758	0	0	0	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0	0	194.01
194.02	07951	LIFELINE	1,574	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	12,592	0	0	0	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	11,018	0	0	0	0	194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,703,070	2,838,328	2,151,923	2,715,046	3,518,054	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/17/2015 3:13 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	20,587,739	0	20,587,739		30.00
32.00	03200	CORONARY CARE UNIT	3,553,143	0	3,553,143		32.00
40.00	04000	SUBPROVIDER - IPF	3,147,496	0	3,147,496		40.00
43.00	04300	NURSERY	847,599	0	847,599		43.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	12,684,931	0	12,684,931		50.00
51.00	05100	RECOVERY ROOM	2,913,824	0	2,913,824		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,440,586	0	1,440,586		52.00
53.00	05300	ANESTHESIOLOGY	2,344,632	0	2,344,632		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,429,916	0	8,429,916		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,531,595	0	2,531,595		55.00
56.00	05600	RADIOISOTOPE	4,303,890	0	4,303,890		56.00
57.00	05700	CT SCAN	2,018,303	0	2,018,303		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,782,842	0	1,782,842		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,845,622	0	1,845,622		59.00
60.00	06000	LABORATORY	12,883,247	0	12,883,247		60.00
65.00	06500	RESPIRATORY THERAPY	1,962,664	0	1,962,664		65.00
66.00	06600	PHYSICAL THERAPY	4,163,251	0	4,163,251		66.00
67.00	06700	OCCUPATIONAL THERAPY	655,889	0	655,889		67.00
68.00	06800	SPEECH PATHOLOGY	917,738	0	917,738		68.00
69.00	06900	ELECTROCARDIOLOGY	2,226,688	0	2,226,688		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,904,052	0	1,904,052		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,803,979	0	5,803,979		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,422,692	0	8,422,692		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,071,057	0	16,071,057		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	878,199	0	878,199		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	907,743	0	907,743		88.00
88.01	08801	RURAL HEALTH CLINIC II	1,081,796	0	1,081,796		88.01
88.02	08802	RURAL HEALTH CLINIC III	1,206,907	0	1,206,907		88.02
88.03	08803	RURAL HEALTH CLINIC IV	549,330	0	549,330		88.03
91.00	09100	EMERGENCY	9,607,294	0	9,607,294		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	6,000,502	0	6,000,502		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	3,158,179	0	3,158,179		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	146,833,325	0	146,833,325		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	59,014,709	0	59,014,709		192.00
194.00	07950	WELLNESS	1,962,745	0	1,962,745		194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	3,446,837	0	3,446,837		194.01
194.02	07951	LIFELINE	183,937	0	183,937		194.02
194.03	07952	OCCUPATIONAL HEALTH	539,293	0	539,293		194.03
194.05	07954	MISC. NONREIMBURSABLE	3,416,022	0	3,416,022		194.05
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	215,396,868	0	215,396,868		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/17/2015 3:13 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	40,629	3,792	44,421	44,421	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	711,598	2,123,743	2,835,341	4,992	5.00
7.00	00700	OPERATION OF PLANT	0	352,423	171,246	523,669	408	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	11,796	0	11,796	10	8.00
9.00	00900	HOUSEKEEPING	0	103,061	12,947	116,008	516	9.00
10.00	01000	DIETARY	0	72,906	55,599	128,505	149	10.00
11.00	01100	CAFETERIA	0	44,128	22,511	66,639	367	11.00
13.00	01300	NURSING ADMINISTRATION	0	15,739	2,689	18,428	630	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	70,851	158,309	229,160	176	14.00
15.00	01500	PHARMACY	0	32,599	24,928	57,527	570	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	35,364	140,346	175,710	564	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	371,982	381,489	753,471	4,467	30.00
32.00	03200	CORONARY CARE UNIT	0	49,226	177,021	226,247	562	32.00
40.00	04000	SUBPROVIDER - IPF	0	96,819	19,488	116,307	1,084	40.00
43.00	04300	NURSERY	0	6,853	15,265	22,118	173	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	388,542	1,063,161	1,451,703	1,640	50.00
51.00	05100	RECOVERY ROOM	0	17,471	9,758	27,229	514	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	15,627	97,884	113,511	262	52.00
53.00	05300	ANESTHESIOLOGY	0	7,175	81,922	89,097	1,990	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	150,343	620,629	770,972	1,978	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	75,994	83,346	159,340	781	55.00
56.00	05600	RADIOISOTOPE	0	21,636	741,860	763,496	423	56.00
57.00	05700	CT SCAN	0	16,949	158,740	175,689	158	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	22,691	399,059	421,750	117	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	31,566	330,665	362,231	200	59.00
60.00	06000	LABORATORY	0	98,496	392,284	490,780	1,722	60.00
65.00	06500	RESPIRATORY THERAPY	0	17,160	63,872	81,032	341	65.00
66.00	06600	PHYSICAL THERAPY	0	159,695	46,513	206,208	644	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,687	5,636	10,323	141	67.00
68.00	06800	SPEECH PATHOLOGY	0	34,365	21,331	55,696	288	68.00
69.00	06900	ELECTROCARDIOLOGY	0	63,676	88,118	151,794	419	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	50,992	50,935	101,927	315	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	30,200	3,571	33,771	190	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	158,207	7,708	165,915	92	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	77,093	6,654	83,747	173	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	31,444	8,352	39,796	245	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	16,234	16,234	82	88.03
91.00	09100	EMERGENCY	0	99,785	150,735	250,520	2,816	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	44,317	90,052	134,369	1,223	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	16,660	0	16,660	500	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	3,650,745	7,848,392	11,499,137	31,922	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,064,555	339,923	1,404,478	11,199	192.00
194.00	07950	WELLNESS	0	0	72,794	72,794	232	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	29,608	29,608	401	194.01
194.02	07951	LIFELINE	0	2,666	0	2,666	10	194.02
194.03	07952	OCCUPATIONAL HEALTH	0	32,332	9,241	41,573	123	194.03
194.05	07954	MISC. NONREIMBURSABLE	0	204,234	102,004	306,238	534	194.05
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	4,954,532	8,401,962	13,356,494	44,421	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/17/2015 3:13 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,840,333					5.00
7.00	00700	OPERATION OF PLANT	81,297	605,374				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,984	1,653	23,443			8.00
9.00	00900	HOUSEKEEPING	34,540	14,447	920	166,431		9.00
10.00	01000	DIETARY	14,834	10,220	188	0	153,896	10.00
11.00	01100	CAFETERIA	19,880	6,186	0	7,885	0	11.00
13.00	01300	NURSING ADMINISTRATION	36,293	2,206	0	1,446	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	26,071	9,932	226	2,628	0	14.00
15.00	01500	PHARMACY	34,563	4,103	0	1,139	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	44,604	6,000	0	964	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	224,275	52,144	7,562	2,037	127,479	30.00
32.00	03200	CORONARY CARE UNIT	40,682	7,642	574	6,089	6,270	32.00
40.00	04000	SUBPROVIDER - IPF	33,721	13,572	503	6,746	16,620	40.00
43.00	04300	NURSERY	9,777	961	224	0	0	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	135,991	56,173	3,809	36,311	769	50.00
51.00	05100	RECOVERY ROOM	31,785	13,237	1,524	2,190	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,575	2,191	612	0	0	52.00
53.00	05300	ANESTHESIOLOGY	29,318	1,006	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	103,987	21,075	953	4,293	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	29,495	10,653	429	3,942	0	55.00
56.00	05600	RADIOISOTOPE	53,019	3,033	559	1,752	0	56.00
57.00	05700	CT SCAN	21,766	2,376	430	964	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	21,049	3,181	188	438	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	21,476	4,425	319	3,066	0	59.00
60.00	06000	LABORATORY	160,140	17,581	7	8,169	0	60.00
65.00	06500	RESPIRATORY THERAPY	24,126	2,405	0	1,117	0	65.00
66.00	06600	PHYSICAL THERAPY	48,335	22,386	316	7,009	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,283	657	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	10,995	4,817	6	131	0	68.00
69.00	06900	ELECTROCARDIOLOGY	25,588	8,926	234	6,417	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22,609	7,148	22	2,979	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	63,101	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	92,382	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	168,943	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	10,706	4,233	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,968	22,177	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	12,758	10,807	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	15,252	4,408	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	6,844	2,753	0	0	0	88.03
91.00	09100	EMERGENCY	105,280	27,779	3,810	20,588	2,758	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	77,455	6,212	0	723	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	40,641	2,335	0	679	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,977,388	391,040	23,415	129,702	153,896	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	747,193	155,067	12	29,896	0	192.00
194.00	07950	WELLNESS	21,289	30,437	16	657	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	45,452	0	0	0	0	194.01
194.02	07951	LIFELINE	2,355	374	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	5,949	4,532	0	1,752	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	40,707	23,924	0	4,424	0	194.05
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)	2,840,333	605,374	23,443	166,431	153,896	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/17/2015 3:13 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	100,957					11.00
13.00	01300	NURSING ADMINISTRATION	2,333	61,336				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,306	0	269,499			14.00
15.00	01500	PHARMACY	1,959	0	0	99,861		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,452	0	0	0	231,294	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,130	26,981	0	0	11,216	30.00
32.00	03200	CORONARY CARE UNIT	2,239	3,402	0	0	1,540	32.00
40.00	04000	SUBPROVIDER - IPF	2,239	2,738	0	0	1,590	40.00
43.00	04300	NURSERY	840	1,358	0	0	790	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,651	11,677	0	0	25,517	50.00
51.00	05100	RECOVERY ROOM	2,146	3,190	0	0	6,415	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,120	1,966	0	0	2,054	52.00
53.00	05300	ANESTHESIOLOGY	1,773	257	0	0	4,554	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,452	0	0	0	11,015	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,053	0	0	0	4,687	55.00
56.00	05600	RADIOISOTOPE	1,026	0	0	0	12,293	56.00
57.00	05700	CT SCAN	653	0	0	0	19,841	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	467	0	0	0	8,721	58.00
59.00	05900	CARDIAC CATHETERIZATION	746	0	0	0	6,390	59.00
60.00	06000	LABORATORY	8,398	0	0	0	18,451	60.00
65.00	06500	RESPIRATORY THERAPY	1,586	0	0	0	4,141	65.00
66.00	06600	PHYSICAL THERAPY	2,426	0	0	0	6,614	66.00
67.00	06700	OCCUPATIONAL THERAPY	467	0	0	0	867	67.00
68.00	06800	SPEECH PATHOLOGY	1,026	0	0	0	994	68.00
69.00	06900	ELECTROCARDIOLOGY	2,053	0	0	0	2,968	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,306	0	0	0	2,883	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	110,495	0	8,963	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	159,004	0	9,677	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	99,861	35,964	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,306	0	0	0	77	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	119	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	277	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	354	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	149	88.03
91.00	09100	EMERGENCY	7,464	9,767	0	0	17,654	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,120	0	0	0	2,134	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	280	0	0	0	2,385	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	82,017	61,336	269,499	99,861	231,294	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	15,862	0	0	0	0	192.00
194.00	07950	WELLNESS	1,586	0	0	0	0	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0	0	194.01
194.02	07951	LIFELINE	93	0	0	0	0	194.02
194.03	07952	OCCUPATIONAL HEALTH	746	0	0	0	0	194.03
194.05	07954	MISC. NONREIMBURSABLE	653	0	0	0	0	194.05
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)	100,957	61,336	269,499	99,861	231,294	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/17/2015 3:13 pm

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1,228,762	0	1,228,762		30.00
32.00	03200	CORONARY CARE UNIT	295,247	0	295,247		32.00
40.00	04000	SUBPROVIDER - IPF	195,120	0	195,120		40.00
43.00	04300	NURSERY	36,241	0	36,241		43.00
45.00	04500	NURSING FACILITY	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,731,241	0	1,731,241		50.00
51.00	05100	RECOVERY ROOM	88,230	0	88,230		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	138,291	0	138,291		52.00
53.00	05300	ANESTHESIOLOGY	127,995	0	127,995		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	917,725	0	917,725		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	211,380	0	211,380		55.00
56.00	05600	RADIOISOTOPE	835,601	0	835,601		56.00
57.00	05700	CT SCAN	221,877	0	221,877		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	455,911	0	455,911		58.00
59.00	05900	CARDIAC CATHETERIZATION	398,853	0	398,853		59.00
60.00	06000	LABORATORY	705,248	0	705,248		60.00
65.00	06500	RESPIRATORY THERAPY	114,748	0	114,748		65.00
66.00	06600	PHYSICAL THERAPY	293,938	0	293,938		66.00
67.00	06700	OCCUPATIONAL THERAPY	20,738	0	20,738		67.00
68.00	06800	SPEECH PATHOLOGY	73,953	0	73,953		68.00
69.00	06900	ELECTROCARDIOLOGY	198,399	0	198,399		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	139,189	0	139,189		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	182,559	0	182,559		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	261,063	0	261,063		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	304,768	0	304,768		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	50,283	0	50,283		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	197,271	0	197,271		88.00
88.01	08801	RURAL HEALTH CLINIC II	107,762	0	107,762		88.01
88.02	08802	RURAL HEALTH CLINIC III	60,055	0	60,055		88.02
88.03	08803	RURAL HEALTH CLINIC IV	26,062	0	26,062		88.03
91.00	09100	EMERGENCY	448,436	0	448,436		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	223,236	0	223,236		101.00
		SPECIAL PURPOSE COST CENTERS					
116.00	11600	HOSPICE	63,480	0	63,480		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,353,662	0	10,353,662		118.00
		NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,363,707	0	2,363,707		192.00
194.00	07950	WELLNESS	127,011	0	127,011		194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	75,461	0	75,461		194.01
194.02	07951	LIFELINE	5,498	0	5,498		194.02
194.03	07952	OCCUPATIONAL HEALTH	54,675	0	54,675		194.03
194.05	07954	MISC. NONREIMBURSABLE	376,480	0	376,480		194.05
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	13,356,494	0	13,356,494		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/17/2015 3:13 pm

		Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	446,076					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		6,808,313				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,658	3,073	122,111,692			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	64,068	1,720,919	13,714,032	-32,854,063	182,542,805	5.00
7.00	00700	OPERATION OF PLANT	31,730	138,765	1,120,491	0	5,224,757	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	0	28,480	0	641,667	8.00
9.00	00900	HOUSEKEEPING	9,279	10,491	1,417,570	0	2,219,802	9.00
10.00	01000	DIETARY	6,564	45,053	408,301	0	953,323	10.00
11.00	01100	CAFETERIA	3,973	18,241	1,008,428	0	1,277,628	11.00
13.00	01300	NURSING ADMINISTRATION	1,417	2,179	1,729,533	0	2,332,428	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,379	128,282	483,945	0	1,675,543	14.00
15.00	01500	PHARMACY	2,935	20,200	1,566,672	0	2,221,286	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,184	113,726	1,549,360	0	2,866,585	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,491	309,130	12,271,104	0	14,413,559	30.00
32.00	03200	CORONARY CARE UNIT	4,432	143,444	1,543,495	0	2,614,499	32.00
40.00	04000	SUBPROVIDER - IPF	8,717	15,792	2,978,890	0	2,167,168	40.00
43.00	04300	NURSERY	617	12,370	474,119	0	628,318	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	34,982	861,505	4,506,663	0	8,739,807	50.00
51.00	05100	RECOVERY ROOM	1,573	7,907	1,411,438	0	2,042,753	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,407	79,318	719,504	0	1,065,211	52.00
53.00	05300	ANESTHESIOLOGY	646	66,383	5,466,986	0	1,884,163	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,536	502,911	5,434,190	0	6,682,964	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,842	67,537	2,145,094	0	1,895,548	55.00
56.00	05600	RADIOISOTOPE	1,948	601,147	1,162,993	0	3,407,385	56.00
57.00	05700	CT SCAN	1,526	128,631	433,319	0	1,398,866	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,043	323,367	322,762	0	1,352,787	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,842	267,946	550,242	0	1,380,201	59.00
60.00	06000	LABORATORY	8,868	317,877	4,730,368	0	10,291,801	60.00
65.00	06500	RESPIRATORY THERAPY	1,545	51,757	936,376	0	1,550,532	65.00
66.00	06600	PHYSICAL THERAPY	14,378	37,691	1,769,427	0	3,106,381	66.00
67.00	06700	OCCUPATIONAL THERAPY	422	4,567	387,966	0	532,325	67.00
68.00	06800	SPEECH PATHOLOGY	3,094	17,285	790,496	0	706,647	68.00
69.00	06900	ELECTROCARDIOLOGY	5,733	71,404	1,149,787	0	1,644,454	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,591	41,274	865,929	0	1,453,033	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,055,355	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	5,937,165	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	10,857,526	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	2,894	522,615	0	688,044	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,244	6,246	252,229	0	576,342	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,941	5,392	475,303	0	819,953	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,831	6,768	671,961	0	980,215	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	13,155	226,633	0	439,867	88.03
91.00	09100	EMERGENCY	8,984	122,144	7,736,395	0	6,766,067	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,990	72,971	3,359,866	0	4,977,809	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,500	0	1,374,448	0	2,611,864	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	328,691	6,359,742	87,697,410	-32,854,063	127,081,628	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	95,846	275,448	30,843,759	0	48,022,103	192.00
194.00	07950	WELLNESS	0	58,987	637,351	0	1,368,199	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	23,992	1,102,223	0	2,921,098	194.01
194.02	07951	LIFELINE	240	0	26,730	0	151,323	194.02
194.03	07952	OCCUPATIONAL HEALTH	2,911	7,488	337,390	0	382,295	194.03
194.05	07954	MISC. NONREIMBURSABLE	18,388	82,656	1,466,829	0	2,616,159	194.05
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)	4,954,532	8,401,962	25,419,211		32,854,063	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.106923	1.234074	0.208164		0.179980	203.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/17/2015 3:13 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
204.00		Cost to be allocated (per Wkst. B, Part II)			44,421		2,840,333	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000364		0.015560	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/17/2015 3:13 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	388,820					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,062	1,189,950				8.00
9.00	00900	HOUSEKEEPING	9,279	46,722	7,599			9.00
10.00	01000	DIETARY	6,564	9,544	0	151,253		10.00
11.00	01100	CAFETERIA	3,973	0	360	0	1,082	11.00
13.00	01300	NURSING ADMINISTRATION	1,417	0	66	0	25	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,379	11,483	120	0	14	14.00
15.00	01500	PHARMACY	2,635	0	52	0	21	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,854	0	44	0	37	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,491	383,860	93	125,289	205	30.00
32.00	03200	CORONARY CARE UNIT	4,908	29,137	278	6,162	24	32.00
40.00	04000	SUBPROVIDER - IPF	8,717	25,539	308	16,335	24	40.00
43.00	04300	NURSERY	617	11,366	0	0	9	43.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,079	193,338	1,658	756	82	50.00
51.00	05100	RECOVERY ROOM	8,502	77,340	100	0	23	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,407	31,073	0	0	12	52.00
53.00	05300	ANESTHESIOLOGY	646	0	0	0	19	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,536	48,372	196	0	37	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,842	21,778	180	0	22	55.00
56.00	05600	RADIOISOTOPE	1,948	28,360	80	0	11	56.00
57.00	05700	CT SCAN	1,526	21,834	44	0	7	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	2,043	9,519	20	0	5	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,842	16,210	140	0	8	59.00
60.00	06000	LABORATORY	11,292	373	373	0	90	60.00
65.00	06500	RESPIRATORY THERAPY	1,545	0	51	0	17	65.00
66.00	06600	PHYSICAL THERAPY	14,378	16,020	320	0	26	66.00
67.00	06700	OCCUPATIONAL THERAPY	422	0	0	0	5	67.00
68.00	06800	SPEECH PATHOLOGY	3,094	296	6	0	11	68.00
69.00	06900	ELECTROCARDIOLOGY	5,733	11,853	293	0	22	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,591	1,123	136	0	14	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	2,719	0	0	0	14	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	14,244	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,941	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2,831	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	1,768	0	0	0	0	88.03
91.00	09100	EMERGENCY	17,842	193,386	940	2,711	80	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	3,990	0	33	0	12	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	1,500	0	31	0	3	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	251,157	1,188,526	5,922	151,253	879	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	99,597	609	1,365	0	170	192.00
194.00	07950	WELLNESS	19,549	815	30	0	17	194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0	0	194.01
194.02	07951	LIFELINE	240	0	0	0	1	194.02
194.03	07952	OCCUPATIONAL HEALTH	2,911	0	80	0	8	194.03
194.05	07954	MISC. NONREIMBURSABLE	15,366	0	202	0	7	194.05
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)	6,165,109	773,993	2,796,839	1,235,188	1,703,070	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.855946	0.650442	368.053560	8.166370	1,574.001848	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	605,374	23,443	166,431	153,896	100,957	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.556952	0.019701	21.901698	1.017474	93.305915	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/17/2015 3:13 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW 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	800,811					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100				14.00
15.00	01500	PHARMACY	0	0	100			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	582,051,785		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	352,256	0	0	28,252,277		30.00
32.00	03200	CORONARY CARE UNIT	44,422	0	0	3,880,086		32.00
40.00	04000	SUBPROVIDER - IPF	35,752	0	0	4,004,438		40.00
43.00	04300	NURSERY	17,726	0	0	1,989,962		43.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	152,460	0	0	64,273,381		50.00
51.00	05100	RECOVERY ROOM	41,652	0	0	16,159,688		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	25,670	0	0	5,173,210		52.00
53.00	05300	ANESTHESIOLOGY	3,351	0	0	11,471,046		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	27,744,382		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	11,806,220		55.00
56.00	05600	RADIOISOTOPE	0	0	0	30,964,992		56.00
57.00	05700	CT SCAN	0	0	0	49,976,665		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	21,966,007		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	16,096,347		59.00
60.00	06000	LABORATORY	0	0	0	46,475,211		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,430,414		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	16,658,843		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,183,207		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	2,504,326		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	7,475,947		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	7,261,007		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41	0	22,576,605		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	59	0	24,374,671		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	100	90,042,216		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	194,143		76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	300,882		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	696,826		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	890,928		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	374,361		88.03
91.00	09100	EMERGENCY	127,522	0	0	44,469,716		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	5,375,177		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	6,008,604		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	800,811	100	100	582,051,785		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	WELLNESS	0	0	0	0		194.00
194.01	07953	OTHER NONREIMB PROGRAM: PEACE MEAL	0	0	0	0		194.01
194.02	07951	LIFELINE	0	0	0	0		194.02
194.03	07952	OCCUPATIONAL HEALTH	0	0	0	0		194.03
194.05	07954	MISC. NONREIMBURSABLE	0	0	0	0		194.05
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,838,328	2,151,923	2,715,046	3,518,054		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.544317	21,519.230000	27,150.460000	0.006044		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	61,336	269,499	99,861	231,294		204.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/17/2015 3:13 pm

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		13.00	14.00	15.00	16.00		
205.00	Unit cost multiplier (Wkst. B, Part II)	0.076592	2,694.990000	998.610000	0.000397		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/17/2015 3:13 pm

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,587,739		20,587,739	0	20,587,739	30.00
32.00	03200	CORONARY CARE UNIT	3,553,143		3,553,143	0	3,553,143	32.00
40.00	04000	SUBPROVIDER - IPF	3,147,496		3,147,496	0	3,147,496	40.00
43.00	04300	NURSERY	847,599		847,599	0	847,599	43.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,684,931		12,684,931	0	12,684,931	50.00
51.00	05100	RECOVERY ROOM	2,913,824		2,913,824	0	2,913,824	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,440,586		1,440,586	0	1,440,586	52.00
53.00	05300	ANESTHESIOLOGY	2,344,632		2,344,632	200,131	2,544,763	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,429,916		8,429,916	0	8,429,916	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,531,595		2,531,595	0	2,531,595	55.00
56.00	05600	RADIOISOTOPE	4,303,890		4,303,890	0	4,303,890	56.00
57.00	05700	CT SCAN	2,018,303		2,018,303	0	2,018,303	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,782,842		1,782,842	0	1,782,842	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,845,622		1,845,622	0	1,845,622	59.00
60.00	06000	LABORATORY	12,883,247		12,883,247	37,847	12,921,094	60.00
65.00	06500	RESPIRATORY THERAPY	1,962,664	0	1,962,664	0	1,962,664	65.00
66.00	06600	PHYSICAL THERAPY	4,163,251	0	4,163,251	0	4,163,251	66.00
67.00	06700	OCCUPATIONAL THERAPY	655,889	0	655,889	0	655,889	67.00
68.00	06800	SPEECH PATHOLOGY	917,738	0	917,738	0	917,738	68.00
69.00	06900	ELECTROCARDIOLOGY	2,226,688		2,226,688	0	2,226,688	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,904,052		1,904,052	0	1,904,052	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,803,979		5,803,979	0	5,803,979	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,422,692		8,422,692	0	8,422,692	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,071,057		16,071,057	0	16,071,057	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	878,199		878,199	0	878,199	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	907,743		907,743	0	907,743	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,081,796		1,081,796	0	1,081,796	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,206,907		1,206,907	0	1,206,907	88.02
88.03	08803	RURAL HEALTH CLINIC IV	549,330		549,330	0	549,330	88.03
91.00	09100	EMERGENCY	9,607,294		9,607,294	178,350	9,785,644	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,192,548		4,192,548		4,192,548	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,000,502		6,000,502		6,000,502	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,158,179		3,158,179		3,158,179	116.00
200.00		Subtotal (see instructions)	151,025,873	0	151,025,873	416,328	151,442,201	200.00
201.00		Less Observation Beds	4,192,548		4,192,548		4,192,548	201.00
202.00		Total (see instructions)	146,833,325	0	146,833,325	416,328	147,249,653	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/17/2015 3:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,533,100		22,533,100			30.00
32.00	03200	CORONARY CARE UNIT	3,880,086		3,880,086			32.00
40.00	04000	SUBPROVIDER - IPF	4,004,438		4,004,438			40.00
43.00	04300	NURSERY	1,989,962		1,989,962			43.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,459,785	49,813,596	64,273,381	0.197359	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,326,486	12,833,202	16,159,688	0.180314	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,891,330	281,880	5,173,210	0.278470	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,991,176	7,479,870	11,471,046	0.204396	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,100,736	23,643,646	27,744,382	0.303842	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	169,749	11,636,471	11,806,220	0.214429	0.000000	55.00
56.00	05600	RADIOISOTOPE	4,434,915	26,530,077	30,964,992	0.138992	0.000000	56.00
57.00	05700	CT SCAN	8,459,103	41,517,562	49,976,665	0.040385	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,663,830	20,302,177	21,966,007	0.081164	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,703,532	11,392,815	16,096,347	0.114661	0.000000	59.00
60.00	06000	LABORATORY	7,816,463	38,658,748	46,475,211	0.277207	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,347,487	2,082,927	10,430,414	0.188167	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,654,482	15,004,361	16,658,843	0.249912	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	265,725	1,917,482	2,183,207	0.300425	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	238,240	2,266,086	2,504,326	0.366461	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,646,381	5,829,566	7,475,947	0.297847	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	205,671	7,055,336	7,261,007	0.262230	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,115,818	14,460,787	22,576,605	0.257079	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	18,755,994	5,618,677	24,374,671	0.345551	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,374,212	62,668,004	90,042,216	0.178484	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	194,143	194,143	4.523465	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	300,882	300,882			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	696,826	696,826			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	890,928	890,928			88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	374,361	374,361			88.03
91.00	09100	EMERGENCY	8,919,560	35,550,156	44,469,716	0.216041	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,719,177	5,719,177	0.733068	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,375,177	5,375,177			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	6,008,604	6,008,604			116.00
200.00		Subtotal (see instructions)	165,948,261	416,103,524	582,051,785			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	165,948,261	416,103,524	582,051,785			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/17/2015 3:13 pm

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		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
32.00	03200	CORONARY CARE UNIT		32.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
45.00	04500	NURSING FACILITY		45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.197359	50.00
51.00	05100	RECOVERY ROOM	0.180314	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.278470	52.00
53.00	05300	ANESTHESIOLOGY	0.221842	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.303842	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.214429	55.00
56.00	05600	RADIOISOTOPE	0.138992	56.00
57.00	05700	CT SCAN	0.040385	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.081164	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.114661	59.00
60.00	06000	LABORATORY	0.278021	60.00
65.00	06500	RESPIRATORY THERAPY	0.188167	65.00
66.00	06600	PHYSICAL THERAPY	0.249912	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.300425	67.00
68.00	06800	SPEECH PATHOLOGY	0.366461	68.00
69.00	06900	ELECTROCARDIOLOGY	0.297847	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.262230	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.257079	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.345551	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.178484	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4.523465	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
88.03	08803	RURAL HEALTH CLINIC IV		88.03
91.00	09100	EMERGENCY	0.220052	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.733068	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
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

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/17/2015 3:13 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,587,739		20,587,739	0	20,587,739	30.00
32.00	03200	CORONARY CARE UNIT	3,553,143		3,553,143	0	3,553,143	32.00
40.00	04000	SUBPROVIDER - IPF	3,147,496		3,147,496	0	3,147,496	40.00
43.00	04300	NURSERY	847,599		847,599	0	847,599	43.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	12,684,931		12,684,931	0	12,684,931	50.00
51.00	05100	RECOVERY ROOM	2,913,824		2,913,824	0	2,913,824	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,440,586		1,440,586	0	1,440,586	52.00
53.00	05300	ANESTHESIOLOGY	2,344,632		2,344,632	200,131	2,544,763	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,429,916		8,429,916	0	8,429,916	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,531,595		2,531,595	0	2,531,595	55.00
56.00	05600	RADIOISOTOPE	4,303,890		4,303,890	0	4,303,890	56.00
57.00	05700	CT SCAN	2,018,303		2,018,303	0	2,018,303	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,782,842		1,782,842	0	1,782,842	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,845,622		1,845,622	0	1,845,622	59.00
60.00	06000	LABORATORY	12,883,247		12,883,247	37,847	12,921,094	60.00
65.00	06500	RESPIRATORY THERAPY	1,962,664	0	1,962,664	0	1,962,664	65.00
66.00	06600	PHYSICAL THERAPY	4,163,251	0	4,163,251	0	4,163,251	66.00
67.00	06700	OCCUPATIONAL THERAPY	655,889	0	655,889	0	655,889	67.00
68.00	06800	SPEECH PATHOLOGY	917,738	0	917,738	0	917,738	68.00
69.00	06900	ELECTROCARDIOLOGY	2,226,688		2,226,688	0	2,226,688	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,904,052		1,904,052	0	1,904,052	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,803,979		5,803,979	0	5,803,979	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	8,422,692		8,422,692	0	8,422,692	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,071,057		16,071,057	0	16,071,057	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	878,199		878,199	0	878,199	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	907,743		907,743	0	907,743	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,081,796		1,081,796	0	1,081,796	88.01
88.02	08802	RURAL HEALTH CLINIC III	1,206,907		1,206,907	0	1,206,907	88.02
88.03	08803	RURAL HEALTH CLINIC IV	549,330		549,330	0	549,330	88.03
91.00	09100	EMERGENCY	9,607,294		9,607,294	178,350	9,785,644	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,192,548		4,192,548		4,192,548	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	6,000,502		6,000,502		6,000,502	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	3,158,179		3,158,179		3,158,179	116.00
200.00		Subtotal (see instructions)	151,025,873	0	151,025,873	416,328	151,442,201	200.00
201.00		Less Observation Beds	4,192,548		4,192,548		4,192,548	201.00
202.00		Total (see instructions)	146,833,325	0	146,833,325	416,328	147,249,653	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/17/2015 3:13 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	22,533,100		22,533,100			30.00
32.00	03200	CORONARY CARE UNIT	3,880,086		3,880,086			32.00
40.00	04000	SUBPROVIDER - IPF	4,004,438		4,004,438			40.00
43.00	04300	NURSERY	1,989,962		1,989,962			43.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,459,785	49,813,596	64,273,381	0.197359	0.000000	50.00
51.00	05100	RECOVERY ROOM	3,326,486	12,833,202	16,159,688	0.180314	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,891,330	281,880	5,173,210	0.278470	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	3,991,176	7,479,870	11,471,046	0.204396	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,100,736	23,643,646	27,744,382	0.303842	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	169,749	11,636,471	11,806,220	0.214429	0.000000	55.00
56.00	05600	RADIOISOTOPE	4,434,915	26,530,077	30,964,992	0.138992	0.000000	56.00
57.00	05700	CT SCAN	8,459,103	41,517,562	49,976,665	0.040385	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,663,830	20,302,177	21,966,007	0.081164	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	4,703,532	11,392,815	16,096,347	0.114661	0.000000	59.00
60.00	06000	LABORATORY	7,816,463	38,658,748	46,475,211	0.277207	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	8,347,487	2,082,927	10,430,414	0.188167	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,654,482	15,004,361	16,658,843	0.249912	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	265,725	1,917,482	2,183,207	0.300425	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	238,240	2,266,086	2,504,326	0.366461	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,646,381	5,829,566	7,475,947	0.297847	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	205,671	7,055,336	7,261,007	0.262230	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	8,115,818	14,460,787	22,576,605	0.257079	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	18,755,994	5,618,677	24,374,671	0.345551	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,374,212	62,668,004	90,042,216	0.178484	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0.000000	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	194,143	194,143	4.523465	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	300,882	300,882	3.016940	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	696,826	696,826	1.552462	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	890,928	890,928	1.354663	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	374,361	374,361	1.467380	0.000000	88.03
91.00	09100	EMERGENCY	8,919,560	35,550,156	44,469,716	0.216041	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,719,177	5,719,177	0.733068	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	5,375,177	5,375,177			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	6,008,604	6,008,604			116.00
200.00		Subtotal (see instructions)	165,948,261	416,103,524	582,051,785			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	165,948,261	416,103,524	582,051,785			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/17/2015 3:13 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
32.00	03200	CORONARY CARE UNIT		32.00
40.00	04000	SUBPROVIDER - IPF		40.00
43.00	04300	NURSERY		43.00
45.00	04500	NURSING FACILITY		45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	55.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
57.00	05700	CT SCAN	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	59.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000	88.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
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: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part I Date/Time Prepared: 11/17/2015 3:13 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,228,762	0	1,228,762	24,764	49.62	30.00
32.00	CORONARY CARE UNIT	295,247		295,247	2,193	134.63	32.00
40.00	SUBPROVIDER - IPF	195,120	0	195,120	3,692	52.85	40.00
43.00	NURSERY	36,241		36,241	1,358	26.69	43.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	1,755,370		1,755,370	32,007		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	10,518	521,903	30.00
32.00	CORONARY CARE UNIT	1,253	168,691	32.00
40.00	SUBPROVIDER - IPF	926	48,939	40.00
43.00	NURSERY	0	0	43.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30-199)	12,697	739,533	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/17/2015 3:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,731,241	64,273,381	0.026936	7,230,084	194,750	50.00
51.00	05100	RECOVERY ROOM	88,230	16,159,688	0.005460	1,194,660	6,523	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	138,291	5,173,210	0.026732	31,816	851	52.00
53.00	05300	ANESTHESIOLOGY	127,995	11,471,046	0.011158	1,696,558	18,930	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	917,725	27,744,382	0.033078	2,992,472	98,985	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	211,380	11,806,220	0.017904	90,592	1,622	55.00
56.00	05600	RADIOISOTOPE	835,601	30,964,992	0.026985	2,369,708	63,947	56.00
57.00	05700	CT SCAN	221,877	49,976,665	0.004440	5,328,401	23,658	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	455,911	21,966,007	0.020755	939,977	19,509	58.00
59.00	05900	CARDIAC CATHETERIZATION	398,853	16,096,347	0.024779	1,888,597	46,798	59.00
60.00	06000	LABORATORY	705,248	46,475,211	0.015175	4,628,615	70,239	60.00
65.00	06500	RESPIRATORY THERAPY	114,748	10,430,414	0.011001	4,815,841	52,979	65.00
66.00	06600	PHYSICAL THERAPY	293,938	16,658,843	0.017645	945,203	16,678	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,738	2,183,207	0.009499	166,987	1,586	67.00
68.00	06800	SPEECH PATHOLOGY	73,953	2,504,326	0.029530	107,306	3,169	68.00
69.00	06900	ELECTROCARDIOLOGY	198,399	7,475,947	0.026538	926,065	24,576	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	139,189	7,261,007	0.019169	56,773	1,088	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	182,559	22,576,605	0.008086	4,005,751	32,391	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	261,063	24,374,671	0.010710	8,688,969	93,059	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	304,768	90,042,216	0.003385	14,056,578	47,582	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	50,283	194,143	0.259000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	197,271	300,882	0.655642	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	107,762	696,826	0.154647	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	60,055	890,928	0.067407	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	26,062	374,361	0.069617	0	0	88.03
91.00	09100	EMERGENCY	448,436	44,469,716	0.010084	5,077,999	51,207	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	250,228	5,719,177	0.043752	0	0	92.00
200.00		Total (lines 50-199)	8,561,804	538,260,418		67,238,952	870,127	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part III Date/Time Prepared: 11/17/2015 3:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
32.00	03200	CORONARY CARE UNIT	0	0	0		0	32.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0		0	43.00
45.00	04500	NURSING FACILITY	0	0	0		0	45.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,764	0.00	10,518	0		30.00
32.00	03200	CORONARY CARE UNIT	2,193	0.00	1,253	0		32.00
40.00	04000	SUBPROVIDER - IPF	3,692	0.00	926	0		40.00
43.00	04300	NURSERY	1,358	0.00	0	0		43.00
45.00	04500	NURSING FACILITY	0	0.00	0	0		45.00
200.00		Total (lines 30-199)	32,007		12,697	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/17/2015 3:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/17/2015 3:13 pm

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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	0	64,273,381	0.000000	0.000000	7,230,084	50.00
51.00	05100	RECOVERY ROOM	0	16,159,688	0.000000	0.000000	1,194,660	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,173,210	0.000000	0.000000	31,816	52.00
53.00	05300	ANESTHESIOLOGY	0	11,471,046	0.000000	0.000000	1,696,558	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,744,382	0.000000	0.000000	2,992,472	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	11,806,220	0.000000	0.000000	90,592	55.00
56.00	05600	RADIOISOTOPE	0	30,964,992	0.000000	0.000000	2,369,708	56.00
57.00	05700	CT SCAN	0	49,976,665	0.000000	0.000000	5,328,401	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	21,966,007	0.000000	0.000000	939,977	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,096,347	0.000000	0.000000	1,888,597	59.00
60.00	06000	LABORATORY	0	46,475,211	0.000000	0.000000	4,628,615	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,430,414	0.000000	0.000000	4,815,841	65.00
66.00	06600	PHYSICAL THERAPY	0	16,658,843	0.000000	0.000000	945,203	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,183,207	0.000000	0.000000	166,987	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,504,326	0.000000	0.000000	107,306	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,475,947	0.000000	0.000000	926,065	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,261,007	0.000000	0.000000	56,773	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,576,605	0.000000	0.000000	4,005,751	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	24,374,671	0.000000	0.000000	8,688,969	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	90,042,216	0.000000	0.000000	14,056,578	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	194,143	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	300,882	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	696,826	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	890,928	0.000000	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	374,361	0.000000	0.000000	0	88.03
91.00	09100	EMERGENCY	0	44,469,716	0.000000	0.000000	5,077,999	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,719,177	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	538,260,418			67,238,952	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/17/2015 3:13 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	16,525,582	0		50.00
51.00	05100	RECOVERY ROOM	0	1,990,768	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,632	0		52.00
53.00	05300	ANESTHESIOLOGY	0	2,418,354	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,778,270	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	3,547,590	0		55.00
56.00	05600	RADIOISOTOPE	0	6,565,060	0		56.00
57.00	05700	CT SCAN	0	11,872,058	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	5,109,778	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,673,030	0		59.00
60.00	06000	LABORATORY	0	3,400,043	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	578,573	0		65.00
66.00	06600	PHYSICAL THERAPY	0	558,115	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	249,396	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,770,647	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,217,285	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,556,867	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	1,799,815	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,706,487	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0		88.03
91.00	09100	EMERGENCY	0	7,929,431	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,245,737	0		92.00
200.00		Total (lines 50-199)	0	106,494,518	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/17/2015 3:13 pm

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	0.197359	16,525,582	0	0	3,261,472	50.00
51.00	05100	RECOVERY ROOM	0.180314	1,990,768	0	0	358,963	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.278470	1,632	0	0	454	52.00
53.00	05300	ANESTHESIOLOGY	0.204396	2,418,354	0	0	494,302	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.303842	7,778,270	0	0	2,363,365	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.214429	3,547,590	0	0	760,706	55.00
56.00	05600	RADIOISOTOPE	0.138992	6,565,060	0	0	912,491	56.00
57.00	05700	CT SCAN	0.040385	11,872,058	0	0	479,453	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.081164	5,109,778	0	0	414,730	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.114661	3,673,030	0	0	421,153	59.00
60.00	06000	LABORATORY	0.277207	3,400,043	11,040	0	942,516	60.00
65.00	06500	RESPIRATORY THERAPY	0.188167	578,573	0	0	108,868	65.00
66.00	06600	PHYSICAL THERAPY	0.249912	558,115	0	0	139,480	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.300425	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.366461	249,396	0	0	91,394	68.00
69.00	06900	ELECTROCARDIOLOGY	0.297847	1,770,647	0	0	527,382	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.262230	1,217,285	0	0	319,209	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.257079	3,556,867	0	0	914,396	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.345551	1,799,815	0	0	621,928	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.178484	23,706,487	0	68,044	4,231,229	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4.523465	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000				0	88.03
91.00	09100	EMERGENCY	0.216041	7,929,431	0	0	1,713,082	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.733068	2,245,737	0	0	1,646,278	92.00
200.00		Subtotal (see instructions)		106,494,518	11,040	68,044	20,722,851	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		106,494,518	11,040	68,044	20,722,851	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/17/2015 3:13 pm

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
51.00	05100	RECOVERY ROOM	0	0		51.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	3,060	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,145		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0		88.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	3,060	12,145		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,060	12,145		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140189 | Component CCN: 14S189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II | Date/Time Prepared: 11/17/2015 3:13 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,731,241	64,273,381	0.026936	0	0	50.00
51.00	05100	RECOVERY ROOM	88,230	16,159,688	0.005460	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	138,291	5,173,210	0.026732	0	0	52.00
53.00	05300	ANESTHESIOLOGY	127,995	11,471,046	0.011158	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	917,725	27,744,382	0.033078	16,312	540	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	211,380	11,806,220	0.017904	15,418	276	55.00
56.00	05600	RADIOISOTOPE	835,601	30,964,992	0.026985	7,728	209	56.00
57.00	05700	CT SCAN	221,877	49,976,665	0.004440	48,918	217	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	455,911	21,966,007	0.020755	7,718	160	58.00
59.00	05900	CARDIAC CATHETERIZATION	398,853	16,096,347	0.024779	0	0	59.00
60.00	06000	LABORATORY	705,248	46,475,211	0.015175	139,957	2,124	60.00
65.00	06500	RESPIRATORY THERAPY	114,748	10,430,414	0.011001	52,376	576	65.00
66.00	06600	PHYSICAL THERAPY	293,938	16,658,843	0.017645	2,798	49	66.00
67.00	06700	OCCUPATIONAL THERAPY	20,738	2,183,207	0.009499	1,143	11	67.00
68.00	06800	SPEECH PATHOLOGY	73,953	2,504,326	0.029530	246	7	68.00
69.00	06900	ELECTROCARDIOLOGY	198,399	7,475,947	0.026538	36,501	969	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	139,189	7,261,007	0.019169	6,581	126	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	182,559	22,576,605	0.008086	4,622	37	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	261,063	24,374,671	0.010710	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	304,768	90,042,216	0.003385	135,277	458	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	50,283	194,143	0.259000	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	197,271	300,882	0.655642	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	107,762	696,826	0.154647	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	60,055	890,928	0.067407	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	26,062	374,361	0.069617	0	0	88.03
91.00	09100	EMERGENCY	448,436	44,469,716	0.010084	236,585	2,386	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,719,177	0.000000	0	0	92.00
200.00		Total (lines 50-199)	8,311,576	538,260,418		712,180	8,145	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140189 | Component CCN: 14S189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/17/2015 3:13 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
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	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0	0	0	88.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140189 | Component CCN: 14S189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/17/2015 3:13 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	64,273,381	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	16,159,688	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	5,173,210	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	11,471,046	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	27,744,382	0.000000	0.000000	16,312	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	11,806,220	0.000000	0.000000	15,418	55.00
56.00	05600	RADIOISOTOPE	0	30,964,992	0.000000	0.000000	7,728	56.00
57.00	05700	CT SCAN	0	49,976,665	0.000000	0.000000	48,918	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	21,966,007	0.000000	0.000000	7,718	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	16,096,347	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	46,475,211	0.000000	0.000000	139,957	60.00
65.00	06500	RESPIRATORY THERAPY	0	10,430,414	0.000000	0.000000	52,376	65.00
66.00	06600	PHYSICAL THERAPY	0	16,658,843	0.000000	0.000000	2,798	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,183,207	0.000000	0.000000	1,143	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,504,326	0.000000	0.000000	246	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,475,947	0.000000	0.000000	36,501	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,261,007	0.000000	0.000000	6,581	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22,576,605	0.000000	0.000000	4,622	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	24,374,671	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	90,042,216	0.000000	0.000000	135,277	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	194,143	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	300,882	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	696,826	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	890,928	0.000000	0.000000	0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	374,361	0.000000	0.000000	0	88.03
91.00	09100	EMERGENCY	0	44,469,716	0.000000	0.000000	236,585	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	5,719,177	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	538,260,418			712,180	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140189 | Component CCN: 14S189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/17/2015 3:13 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
88.03	08803	RURAL HEALTH CLINIC IV	0	0	0		88.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/17/2015 3:13 pm

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)	24,764	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	24,764	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)	19,721	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)	10,518	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)	20,587,739	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)	20,587,739	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)	20,587,739	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)	831.36	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	8,744,244	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)	8,744,244	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/17/2015 3:13 pm

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						43.00
44.00	CORONARY CARE UNIT	3,553,143	2,193	1,620.22	1,253	2,030,136	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)	14,261,656	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	25,036,036	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)	690,594	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	870,127	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,560,721	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	23,475,315	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)	5,043	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	831.36	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	4,192,548	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/17/2015 3:13 pm

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	1,228,762	20,587,739	0.059684	4,192,548	250,228	90.00
91.00	Nursing School cost	0	20,587,739	0.000000	4,192,548	0	91.00
92.00	Allied health cost	0	20,587,739	0.000000	4,192,548	0	92.00
93.00	All other Medical Education	0	20,587,739	0.000000	4,192,548	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 140189 Component CCN: 14S189	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/17/2015 3:13 pm
	Title XVIII	Subprovider - IPF	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)	3,692	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,692	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3,692	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)	926	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)	3,147,496	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)	3,147,496	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)	3,147,496	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)	852.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	789,434	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)	789,434	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 140189 | Component CCN: 14S189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/17/2015 3:13 pm

Title XVIII | Subprovider - IPF | 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						43.00
44.00	CORONARY CARE UNIT	0	0	0.00	0	0	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)	151,828	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	941,262	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)	48,939	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	8,145	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	57,084	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	884,178	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)	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: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1

Component CCN: 14S189 | Date/Time Prepared: 11/17/2015 3:13 pm

Title XVIII | Subprovider - IPF | 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	195,120	3,147,496	0.061992	0	0	90.00
91.00	Nursing School cost	0	3,147,496	0.000000	0	0	91.00
92.00	Allied health cost	0	3,147,496	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,147,496	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/17/2015 3:13 pm

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		11,114,804		30.00
32.00	03200	CORONARY CARE UNIT		2,125,812		32.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197359	7,230,084	1,426,922	50.00
51.00	05100	RECOVERY ROOM	0.180314	1,194,660	215,414	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.278470	31,816	8,860	52.00
53.00	05300	ANESTHESIOLOGY	0.221842	1,696,558	376,368	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.303842	2,992,472	909,239	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.214429	90,592	19,426	55.00
56.00	05600	RADIOISOTOPE	0.138992	2,369,708	329,370	56.00
57.00	05700	CT SCAN	0.040385	5,328,401	215,187	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.081164	939,977	76,292	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.114661	1,888,597	216,548	59.00
60.00	06000	LABORATORY	0.278021	4,628,615	1,286,852	60.00
65.00	06500	RESPIRATORY THERAPY	0.188167	4,815,841	906,182	65.00
66.00	06600	PHYSICAL THERAPY	0.249912	945,203	236,218	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.300425	166,987	50,167	67.00
68.00	06800	SPEECH PATHOLOGY	0.366461	107,306	39,323	68.00
69.00	06900	ELECTROCARDIOLOGY	0.297847	926,065	275,826	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.262230	56,773	14,888	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.257079	4,005,751	1,029,794	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.345551	8,688,969	3,002,482	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.178484	14,056,578	2,508,874	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4.523465	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
91.00	09100	EMERGENCY	0.220052	5,077,999	1,117,424	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.733068	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		67,238,952	14,261,656	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)		67,238,952		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 140189 | Component CCN: 14S189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/17/2015 3:13 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
32.00	03200	CORONARY CARE UNIT		0		32.00
40.00	04000	SUBPROVIDER - IPF		997,484		40.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197359	0	0	50.00
51.00	05100	RECOVERY ROOM	0.180314	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.278470	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.221842	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.303842	16,312	4,956	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.214429	15,418	3,306	55.00
56.00	05600	RADIOISOTOPE	0.138992	7,728	1,074	56.00
57.00	05700	CT SCAN	0.040385	48,918	1,976	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.081164	7,718	626	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.114661	0	0	59.00
60.00	06000	LABORATORY	0.278021	139,957	38,911	60.00
65.00	06500	RESPIRATORY THERAPY	0.188167	52,376	9,855	65.00
66.00	06600	PHYSICAL THERAPY	0.249912	2,798	699	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.300425	1,143	343	67.00
68.00	06800	SPEECH PATHOLOGY	0.366461	246	90	68.00
69.00	06900	ELECTROCARDIOLOGY	0.297847	36,501	10,872	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.262230	6,581	1,726	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.257079	4,622	1,188	71.00
72.00	07200	IMPLANTABLE DEVICES CHARGED TO PATIENTS	0.345551	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.178484	135,277	24,145	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	75.00
76.00	03550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	4.523465	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
88.03	08803	RURAL HEALTH CLINIC IV	0.000000		0	88.03
91.00	09100	EMERGENCY	0.220052	236,585	52,061	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.733068	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		712,180	151,828	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)		712,180		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Date/Time Prepared: 11/17/2015 3:13 pm

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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)		4,511,958			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		14,750,225			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)		253,211			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)		72.18			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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Date/Time Prepared: 11/17/2015 3:13 pm

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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)		2.73			30.00
31.00	Percentage of Medicaid patient days (see instructions)		19.09			31.00
32.00	Sum of lines 30 and 31		21.82			32.00
33.00	Allowable disproportionate share percentage (see instructions)		7.22			33.00
34.00	Disproportionate share adjustment (see instructions)		347,683			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		7,647,644,855	35.00
35.01	Factor 3 (see instructions)		0.000099973		0.000105058	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		904,394		803,446	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		227,957		600,933	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		828,890			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)		20,691,967			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		23,468,269			48.00
49.00	Total payment for inpatient operating costs (see instructions)		23,468,269			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,528,334			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		0			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).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		24,996,603			59.00
60.00	Primary payer payments		1,416			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		24,995,187			61.00
62.00	Deductibles billed to program beneficiaries		2,487,296			62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Date/Time Prepared: 11/17/2015 3:13 pm

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			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		18,372			63.00
64.00	Allowable bad debts (see instructions)		647,795			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		421,067			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		22,910,586			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)		69,103			70.93
70.94	HRR adjustment amount (see instructions)		-246,859			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)	0	0			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)	0	0			70.97
70.98	Low Volume Payment-3		0			70.98
70.99	HAC adjustment amount (see instructions)		138,121			70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22,594,709			71.00
71.01	Sequestration adjustment (see instructions)		451,894			71.01
72.00	Interim payments		22,038,935			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)		103,880			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: 140189	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Date/Time Prepared: 11/17/2015 3:13 pm
	Title XVIII	Hospital	PPS

		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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/17/2015 3:13 pm

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		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	4,511,958	4,511,958		4,511,958	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	14,750,225		14,750,225	14,750,225	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	253,211	0	253,211	253,211	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	0.0722	0.0722	0.0722		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	347,683	81,441	266,242	347,683	11.00
11.01	Uncompensated care payments	36.00	828,890	227,957	600,933	828,890	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	20,691,967	4,821,356	15,870,611	20,691,967	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	23,468,269	11,051,507	12,416,762	23,468,269	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	23,468,269	11,051,507	12,416,762	23,468,269	15.00
16.00	Payment for inpatient program capital	50.00	1,528,334	0	1,528,334	1,528,334	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			11,051,507	13,945,096	24,996,603	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/17/2015 3:13 pm

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	1,516,364	0	1,516,364	1,516,364	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	11,970	0	11,970	11,970	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	1,528,334	0	1,528,334	1,528,334	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	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	69,103	17,418	51,685	69,103	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	-246,859	-62,222	-184,637	-246,859	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	138,121	138,121	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140189	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/17/2015 3:13 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	15,205	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	20,722,851	2.00
3.00	PPS payments	18,829,583	3.00
4.00	Outlier payment (see instructions)	31,429	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	15,205	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	79,084	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)	79,084	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)	79,084	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	63,879	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)	15,205	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)	18,861,012	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)	4,070,469	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)	14,805,748	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)	14,805,748	30.00
31.00	Primary payer payments	3,462	31.00
32.00	Subtotal (line 30 minus line 31)	14,802,286	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)	978,460	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	635,999	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	15,438,285	37.00
38.00	MSP-LCC reconciliation amount from PS&R	322	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)	15,437,963	40.00
40.01	Sequestration adjustment (see instructions)	308,759	40.01
41.00	Interim payments	15,028,086	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	101,118	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/17/2015 3:13 pm

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		22,185,592		15,017,701	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	02/05/2015	10,385	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	02/05/2015	3,067		0	3.50
3.51		02/05/2015	143,590		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)		-146,657		10,385	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)		22,038,935		15,028,086	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		103,880		101,118	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		22,142,815		15,129,204	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: 140189 | Component CCN: 14S189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/17/2015 3:13 pm

Title XVIII | Subprovider - IPF | 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		615,203		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		615,203		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		71,302		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		686,505		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 140189	Period: From 07/01/2014 To 06/30/2015	Worksheet E-1 Part II Date/Time Prepared: 11/17/2015 3:13 pm
	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	6,455	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	11,771	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	2,078	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	21,914	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	582,051,785	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	12,464,300	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)	494,231	8.00
9.00	Sequestration adjustment amount (see instructions)	9,885	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	484,346	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	484,346	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140189 Component CCN: 14S189	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part II Date/Time Prepared: 11/17/2015 3:13 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	804,187	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	10.115068	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	804,187	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	804,187	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	804,187	18.00
19.00	Deductibles	169,417	19.00
20.00	Subtotal (line 18 minus line 19)	634,770	20.00
21.00	Coinsurance	6,930	21.00
22.00	Subtotal (line 20 minus line 21)	627,840	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	111,808	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	72,675	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	700,515	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	700,515	31.00
31.01	Sequestration adjustment (see instructions)	14,010	31.01
32.00	Interim payments	615,203	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	71,302	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/17/2015 3:13 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	42,173,925	0	0	0	1.00
2.00	Temporary investments	15,881,781	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	89,024,317	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-55,298,100	0	0	0	6.00
7.00	Inventory	4,180,615	0	0	0	7.00
8.00	Prepaid expenses	3,823,086	0	0	0	8.00
9.00	Other current assets	2,502,567	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)	102,288,191	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	3,405,746	0	0	0	12.00
13.00	Land improvements	8,640,109	0	0	0	13.00
14.00	Accumulated depreciation	-4,294,974	0	0	0	14.00
15.00	Buildings	136,237,687	0	0	0	15.00
16.00	Accumulated depreciation	-43,265,246	0	0	0	16.00
17.00	Leasehold improvements	607,552	0	0	0	17.00
18.00	Accumulated depreciation	-319,126	0	0	0	18.00
19.00	Fixed equipment	16,280,584	0	0	0	19.00
20.00	Accumulated depreciation	-11,394,729	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	77,185,977	0	0	0	23.00
24.00	Accumulated depreciation	-53,349,157	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	129,734,423	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	113,912,024	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	80,787,052	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	194,699,076	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	426,721,690	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	9,269,137	0	0	0	37.00
38.00	Salaries, wages, and fees payable	22,217,911	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,670,000	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	8,305,738	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)	42,462,786	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	85,306,831	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	85,306,831	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	127,769,617	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	298,952,073				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)	298,952,073	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	426,721,690	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/17/2015 3:13 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		261,184,711		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		37,767,362				2.00
3.00	Total (sum of line 1 and line 2)		298,952,073		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		298,952,073		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		298,952,073		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/17/2015 3:13 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	22,533,100		22,533,100	1.00
2.00	SUBPROVIDER - IPF	4,004,438		4,004,438	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	26,537,538		26,537,538	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT	3,880,086		3,880,086	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)	3,880,086		3,880,086	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	30,417,624		30,417,624	17.00
18.00	Ancillary services	133,540,675	366,712,547	500,253,222	18.00
19.00	Outpatient services	0	35,744,299	35,744,299	19.00
20.00	RURAL HEALTH CLINIC	0	300,882	300,882	20.00
20.01	RURAL HEALTH CLINIC II	0	696,826	696,826	20.01
20.02	RURAL HEALTH CLINIC III	0	890,928	890,928	20.02
20.03	RURAL HEALTH CLINIC IV	0	374,361	374,361	20.03
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		5,375,177	5,375,177	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	0	6,008,604	6,008,604	26.00
27.00	NURS IP,HOMKR,OCC HLTH,ACCRLS	2,214,057	1,305,564	3,519,621	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	166,172,356	417,409,188	583,581,544	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		248,021,026		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)		248,021,026		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-3 | Date/Time Prepared: 11/17/2015 3:13 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	583,581,544	1.00
2.00	Less contractual allowances and discounts on patients' accounts	359,699,159	2.00
3.00	Net patient revenues (line 1 minus line 2)	223,882,385	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	248,021,026	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-24,138,641	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	40,354	6.00
7.00	Income from investments	6,432,892	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	246,572	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	784,504	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	96,052	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	18,099	21.00
22.00	Rental of hospital space	363,804	22.00
23.00	Governmental appropriations	0	23.00
24.00	PHYS REV, GRANTS, MISC OTHER	53,923,726	24.00
25.00	Total other income (sum of lines 6-24)	61,906,003	25.00
26.00	Total (line 5 plus line 25)	37,767,362	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	37,767,362	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140189 | HHA CCN: 147594 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H | Date/Time Prepared: 11/17/2015 3:13 pm

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	858,472	236,923	70,426	205,785	271,036	1,642,642	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,628,053	0	0	0	0	1,628,053	6.00
7.00	Physical Therapy	483,653	0	0	0	0	483,653	7.00
8.00	Occupational Therapy	212,795	0	0	0	0	212,795	8.00
9.00	Speech Pathology	49,129	0	0	0	0	49,129	9.00
10.00	Medical Social Services	31,833	0	0	0	0	31,833	10.00
11.00	Home Health Aide	95,932	0	0	0	0	95,932	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	3,359,867	236,923	70,426	205,785	271,036	4,144,037	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	0	1,642,642	0	1,642,642			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	1,628,053	0	1,628,053			6.00
7.00	Physical Therapy	0	483,653	0	483,653			7.00
8.00	Occupational Therapy	0	212,795	0	212,795			8.00
9.00	Speech Pathology	0	49,129	0	49,129			9.00
10.00	Medical Social Services	0	31,833	0	31,833			10.00
11.00	Home Health Aide	0	95,932	0	95,932			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	0	4,144,037	0	4,144,037			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: 140189 HHA CCN: 147594

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

Worksheet H-1 Part I Date/Time Prepared: 11/17/2015 3:13 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	1,642,642	0	0	0	0	1,642,642	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	1,628,053	0	0	0	0	1,628,053	6.00
7.00	Physical Therapy	483,653	0	0	0	0	483,653	7.00
8.00	Occupational Therapy	212,795	0	0	0	0	212,795	8.00
9.00	Speech Pathology	49,129	0	0	0	0	49,129	9.00
10.00	Medical Social Services	31,833	0	0	0	0	31,833	10.00
11.00	Home Health Aide	95,932	0	0	0	0	95,932	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	4,144,037	0	0	0	0	4,144,037	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	1,642,642		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	1,069,127	2,697,180	6.00
7.00	Physical Therapy	317,610	801,263	7.00
8.00	Occupational Therapy	139,740	352,535	8.00
9.00	Speech Pathology	32,263	81,392	9.00
10.00	Medical Social Services	20,904	52,737	10.00
11.00	Home Health Aide	62,998	158,930	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		4,144,037	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 140189 HHA CCN: 147594 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-1 Part II Date/Time Prepared: 11/17/2015 3:13 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-1,642,642	2,501,395	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	1,628,053	6.00
7.00	Physical Therapy	0	0	0	0	0	483,653	7.00
8.00	Occupational Therapy	0	0	0	0	0	212,795	8.00
9.00	Speech Pathology	0	0	0	0	0	49,129	9.00
10.00	Medical Social Services	0	0	0	0	0	31,833	10.00
11.00	Home Health Aide	0	0	0	0	0	95,932	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-1,642,642	2,501,395	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		1,642,642	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.656690	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-2 Part I
HHA CCN: 147594 | Date/Time Prepared: 11/17/2015 3:13 pm

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	44,317	90,052	699,403	833,772	150,062	1.00
2.00	Skilled Nursing Care	2,697,180	0	0	0	2,697,180	485,439	2.00
3.00	Physical Therapy	801,263	0	0	0	801,263	144,211	3.00
4.00	Occupational Therapy	352,535	0	0	0	352,535	63,449	4.00
5.00	Speech Pathology	81,392	0	0	0	81,392	14,649	5.00
6.00	Medical Social Services	52,737	0	0	0	52,737	9,492	6.00
7.00	Home Health Aide	158,930	0	0	0	158,930	28,604	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	4,144,037	44,317	90,052	699,403	4,977,809	895,906	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	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	63,265	0	12,146	0	18,888	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	63,265	0	12,146	0	18,888	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: 140189 HHA CCN: 147594 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-2 Part I Date/Time Prepared: 11/17/2015 3:13 pm

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	32,488	1,110,621	0	1,110,621	1.00
2.00	Skilled Nursing Care	0	0	0	3,182,619	0	3,182,619	2.00
3.00	Physical Therapy	0	0	0	945,474	0	945,474	3.00
4.00	Occupational Therapy	0	0	0	415,984	0	415,984	4.00
5.00	Speech Pathology	0	0	0	96,041	0	96,041	5.00
6.00	Medical Social Services	0	0	0	62,229	0	62,229	6.00
7.00	Home Health Aide	0	0	0	187,534	0	187,534	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	32,488	6,000,502	0	6,000,502	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	Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	722,857	3,905,476	2.00
3.00	Physical Therapy	214,742	1,160,216	3.00
4.00	Occupational Therapy	94,481	510,465	4.00
5.00	Speech Pathology	21,813	117,854	5.00
6.00	Medical Social Services	14,134	76,363	6.00
7.00	Home Health Aide	42,594	230,128	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,110,621	6,000,502	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.	0.227126		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: 140189 HHA CCN: 147594

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

Worksheet H-2 Part II Date/Time Prepared: 11/17/2015 3:13 pm

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	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	3,990	72,971	3,359,866	0	833,772	3,990	1.00
2.00	Skilled Nursing Care	0	0	0	0	2,697,180	0	2.00
3.00	Physical Therapy	0	0	0	0	801,263	0	3.00
4.00	Occupational Therapy	0	0	0	0	352,535	0	4.00
5.00	Speech Pathology	0	0	0	0	81,392	0	5.00
6.00	Medical Social Services	0	0	0	0	52,737	0	6.00
7.00	Home Health Aide	0	0	0	0	158,930	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)	3,990	72,971	3,359,866		4,977,809	3,990	20.00
21.00	Total cost to be allocated	44,317	90,052	699,403		895,906	63,265	21.00
22.00	Unit cost multiplier	11.107018	1.234079	0.208164		0.179980	15.855890	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	33	0	12	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	33	0	12	0	0	20.00
21.00	Total cost to be allocated	0	12,146	0	18,888	0	0	21.00
22.00	Unit cost multiplier	0.000000	368.060606	0.000000	1,574.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140189 HHA CCN: 147594

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

Worksheet H-2 Part II Date/Time Prepared: 11/17/2015 3:13 pm

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)				
		15.00	16.00				
1.00	Administrative and General	0	5,375,177				1.00
2.00	Skilled Nursing Care	0	0				2.00
3.00	Physical Therapy	0	0				3.00
4.00	Occupational Therapy	0	0				4.00
5.00	Speech Pathology	0	0				5.00
6.00	Medical Social Services	0	0				6.00
7.00	Home Health Aide	0	0				7.00
8.00	Supplies (see instructions)	0	0				8.00
9.00	Drugs	0	0				9.00
10.00	DME	0	0				10.00
11.00	Home Dialysis Aide Services	0	0				11.00
12.00	Respiratory Therapy	0	0				12.00
13.00	Private Duty Nursing	0	0				13.00
14.00	Clinic	0	0				14.00
15.00	Health Promotion Activities	0	0				15.00
16.00	Day Care Program	0	0				16.00
17.00	Home Delivered Meals Program	0	0				17.00
18.00	Homemaker Service	0	0				18.00
19.00	All Others (specify)	0	0				19.00
20.00	Total (sum of lines 1-19)	0	5,375,177				20.00
21.00	Total cost to be allocated	0	32,488				21.00
22.00	Unit cost multiplier	0.000000	0.006044				22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140189 | HHA CCN: 147594 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-3 Part I | Date/Time Prepared: 11/17/2015 3:13 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	3,905,476		3,905,476	20,001	195.26	1.00
2.00	Physical Therapy	3.00	1,160,216	0	1,160,216	5,805	199.86	2.00
3.00	Occupational Therapy	4.00	510,465	0	510,465	2,176	234.59	3.00
4.00	Speech Pathology	5.00	117,854	0	117,854	367	321.13	4.00
5.00	Medical Social Services	6.00	76,363		76,363	237	322.21	5.00
6.00	Home Health Aide	7.00	230,128		230,128	3,068	75.01	6.00
7.00	Total (sum of lines 1-6)		6,000,502	0	6,000,502	31,654		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	13,810			8.00
9.00	Physical Therapy		99914	0	3,667			9.00
10.00	Occupational Therapy		99914	0	1,306			10.00
11.00	Speech Pathology		99914	0	158			11.00
12.00	Medical Social Services		99914	0	160			12.00
13.00	Home Health Aide		99914	0	2,562			13.00
14.00	Total (sum of lines 8-13)			0	21,663			14.00

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

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	13,810		0	2,696,541		1.00
2.00	Physical Therapy	0	3,667		0	732,887		2.00
3.00	Occupational Therapy	0	1,306		0	306,375		3.00
4.00	Speech Pathology	0	158		0	50,739		4.00
5.00	Medical Social Services	0	160		0	51,554		5.00
6.00	Home Health Aide	0	2,562		0	192,176		6.00
7.00	Total (sum of lines 1-6)	0	21,663		0	4,030,272		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 140189 HHA CCN: 147594 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-3 Part I Date/Time Prepared: 11/17/2015 3:13 pm

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	2,696,541	1.00
2.00	Physical Therapy	732,887	2.00
3.00	Occupational Therapy	306,375	3.00
4.00	Speech Pathology	50,739	4.00
5.00	Medical Social Services	51,554	5.00
6.00	Home Health Aide	192,176	6.00
7.00	Total (sum of lines 1-6)	4,030,272	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140189 HHA CCN: 147594 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-3 Part II Date/Time Prepared: 11/17/2015 3:13 pm

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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	0.249912	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.300425	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.366461	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.257079	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.178484	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 140189 | HHA CCN: 147594 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/17/2015 3:13 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	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	2,872,731	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	69,211	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	61,531	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	34,106	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	27,342	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	2,924	16.00
17.00	Total Other Payments	0	-61,014	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	3,006,831	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	3,006,831	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	3,006,831	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	3,006,831	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	3,006,831	31.00
31.01	Sequestration adjustment (see instructions)	0	0	31.01
32.00	Interim payments (see instructions)	0	3,006,831	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 140189 HHA CCN: 147594

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

Worksheet H-5

Date/Time Prepared: 11/17/2015 3:13 pm

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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		3,006,831	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		3,006,831	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		3,006,831	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: 140189 Hospice CCN: 141599

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

Worksheet K

Date/Time Prepared: 11/17/2015 3:13 pm

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	228,688	0	0	0	934,645	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	1,145,760	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	Total (sum of lines 1 thru 38)	1,374,448	0	0	0	934,645	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

Provider CCN: 140189 Hospice CCN: 141599 | Period: From 07/01/2014 To 06/30/2015 | Worksheet K | Date/Time Prepared: 11/17/2015 3:13 pm

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	1,163,333	0	1,163,333	0	1,163,333	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	1,145,760	0	1,145,760	0	1,145,760	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	Total (sum of lines 1 thru 38)	2,309,093	0	2,309,093	0	2,309,093	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140189 Hospice CCN: 141599

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

Worksheet K-1

Date/Time Prepared: 11/17/2015 3:13 pm

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	120,753	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	186,370	0	859,805	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	120,753	186,370	0	859,805	39.00

HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

Provider CCN: 140189 Hospice CCN: 141599

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

Worksheet K-1

Date/Time Prepared: 11/17/2015 3:13 pm

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	107,935	228,688		6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care		99,585	0	1,145,760		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	0	0		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	99,585	107,935	1,374,448		39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140189 Hospice CCN: 141599

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

Worksheet K-4 Part I Date/Time Prepared: 11/17/2015 3:13 pm

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	1,163,333	0	0	0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	1,145,760	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	Total (sum of lines 1 thru 38)	2,309,093	0	0	0	0	39.00

COST ALLOCATION - HOSPICE GENERAL SERVICE COST

Provider CCN: 140189 Hospice CCN: 141599

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

Worksheet K-4 Part I Date/Time Prepared: 11/17/2015 3:13 pm

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	1,163,333	1,163,333			6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	1,145,760	1,163,333	2,309,093		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	0	0	0		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	2,309,093		2,309,093		39.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 140189 Hospice CCN: 141599 | Period: From 07/01/2014 To 06/30/2015 | Worksheet K-4 Part II Date/Time Prepared: 11/17/2015 3:13 pm

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: 140189 Hospice CCN: 141599 | Period: From 07/01/2014 To 06/30/2015 | Worksheet K-4 Part II Date/Time Prepared: 11/17/2015 3:13 pm

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	-1,163,333	1,145,760		6.00
	INPATIENT CARE SERVICE				
7.00	Inpatient - General Care	0	1,145,760		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	0		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)		1,163,333		39.00
40.00	Unit Cost Multiplier		1.015337		40.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189
Hospice CCN: 141599

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

Worksheet K-5
Part I
Date/Time Prepared:
11/17/2015 3:13 pm

Hospice I

	Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
1.00	Administrative and General		16,660	0	286,111	302,771	1.00
2.00	Inpatient - General Care	2,309,093	0	0	0	2,309,093	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)	2,309,093	16,660	0	286,111	2,611,864	34.00
35.00	Unit Cost Multiplier (see instructions)					0.000000	35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189
Hospice CCN: 141599

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

Worksheet K-5
Part I
Date/Time Prepared:
11/17/2015 3:13 pm

Hospice I

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	54,493	23,784	0	11,410	0	1.00
2.00	Inpatient - General Care	415,590	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)	470,083	23,784	0	11,410	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189
Hospice CCN: 141599

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

Worksheet K-5
Part I
Date/Time Prepared:
11/17/2015 3:13 pm

Hospice I

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	4,722	0	0	0	36,316	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)	4,722	0	0	0	36,316	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Provider CCN: 140189 Hospice CCN: 141599

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

Worksheet K-5 Part I Date/Time Prepared: 11/17/2015 3:13 pm

Hospice I

	Cost Center Description	Subtotal (cols. 4A-23)	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal (cols. 24 ± 25)	Allocated Hospice A&G (See Part II)	Total Hospice Costs (cols. 26 ± 27)	
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	433,496					1.00
2.00	Inpatient - General Care	2,724,683	0	2,724,683	433,496	3,158,179	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)	3,158,179	0	3,158,179		3,158,179	34.00
35.00	Unit Cost Multiplier (see instructions)				0.159100		35.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140189
Hospice CCN: 141599

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

Worksheet K-5
Part II
Date/Time Prepared:
11/17/2015 3:13 pm

Hospice I

	Cost Center Description	CAPITAL RELATED COSTS					
		NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
1.00	Administrative and General	16,660	0	286,111	0	302,771	1.00
2.00	Inpatient - General Care	0	0	0	0	2,309,093	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)	16,660	0	286,111		2,611,864	34.00
35.00	Total cost to be allocated	16,660	0	286,111		470,083	35.00
36.00	Unit Cost Multiplier (see instructions)	1.000000	0.000000	1.000000		0.179980	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140189
Hospice CCN: 141599

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

Worksheet K-5
Part II
Date/Time Prepared:
11/17/2015 3:13 pm

Hospice I

	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	23,784	0	11,410	0	4,722	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)	23,784	0	11,410	0	4,722	34.00
35.00	Total cost to be allocated	23,784	0	11,410	0	4,722	35.00
36.00	Unit Cost Multiplier (see instructions)	1.000000	0.000000	1.000000	0.000000	1.000000	36.00

ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS
STATISTICAL BASIS

Provider CCN: 140189
Hospice CCN: 141599

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

Worksheet K-5
Part II
Date/Time Prepared:
11/17/2015 3:13 pm

Hospice I

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)		
		13.00	14.00	15.00	16.00		
1.00	Administrative and General	0	0	0	36,316		1.00
2.00	Inpatient - General Care	0	0	0	0		2.00
3.00	Inpatient - Respite Care	0	0	0	0		3.00
4.00	Physician Services	0	0	0	0		4.00
5.00	Nursing Care	0	0	0	0		5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0		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/ Language Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	0	0	0		10.00
11.00	Spiritual Counseling	0	0	0	0		11.00
12.00	Dietary Counseling	0	0	0	0		12.00
13.00	Counseling - Other	0	0	0	0		13.00
14.00	Home Health Aide and Homemaker	0	0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0		15.00
16.00	Other	0	0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0		17.00
18.00	Analgesics	0	0	0	0		18.00
19.00	Sedatives / Hypnotics	0	0	0	0		19.00
20.00	Other - Specify	0	0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0		21.00
22.00	Patient Transportation	0	0	0	0		22.00
23.00	Imaging Services	0	0	0	0		23.00
24.00	Labs and Diagnostics	0	0	0	0		24.00
25.00	Medical Supplies	0	0	0	0		25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0		26.00
27.00	Radiation Therapy	0	0	0	0		27.00
28.00	Chemotherapy	0	0	0	0		28.00
29.00	Other	0	0	0	0		29.00
30.00	Bereavement Program Costs	0	0	0	0		30.00
31.00	Volunteer Program Costs	0	0	0	0		31.00
32.00	Fundraising	0	0	0	0		32.00
33.00	Other Program Costs	0	0	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	36,316		34.00
35.00	Total cost to be allocated	0	0	0	36,316		35.00
36.00	Unit Cost Multiplier (see instructions)	0.000000	0.000000	0.000000	1.000000		36.00

COMPUTATION OF TOTAL HOSPICE SHARED COSTS

Provider CCN: 140189 Hospice CCN: 141599

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

Worksheet K-5 Part III Date/Time Prepared: 11/17/2015 3:13 pm

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	0.249912	0	0	1.00
2.00	OCCUPATIONAL THERAPY	67.00	0.300425	0	0	2.00
3.00	SPEECH PATHOLOGY	68.00	0.366461	0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0.178484	0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00				5.00
6.00	LABORATORY	60.00	0.278021	0	0	6.00
6.01	BLOOD LABORATORY	60.01				6.01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0.257079	0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				8.00
9.00	RADIOLOGY-THERAPEUTIC	55.00	0.214429	0	0	9.00
10.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	76.00	4.523465	0	0	10.00
11.00	Totals (sum of lines 1-10)				0	11.00

CALCULATION OF HOSPICE PER DIEM COST

Provider CCN: 140189 Hospice CCN: 141599

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

Worksheet K-6

Date/Time Prepared: 11/17/2015 3:13 pm

Hospice I

		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	
1.00	Total cost (see instructions)				3,158,179	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				21,573	2.00
3.00	Average cost per diem (line 1 divided by line 2)				146.39	3.00
4.00	Updduplicated Medicare Days (Worksheet S-9, column 1, line 5)	18,340				4.00
5.00	Aggregate Medicare cost (line 3 time line 4)	2,684,793				5.00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)		1,750			6.00
7.00	Aggregate Medicaid cost (line 3 time line 60)		256,183			7.00
8.00	Updduplicated SNF Days (Worksheet S-9, column 3, line 5)	9,435				8.00
9.00	Aggregate SNF cost (line 3 time line 8)	1,381,190				9.00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)		934			10.00
11.00	Aggregate NF cost (line 3 times line 10)		136,728			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			1,483		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			217,096		13.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 140189	Period: From 07/01/2014 To 06/30/2015	Worksheet L Parts I-III Date/Time Prepared: 11/17/2015 3:13 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,516,364	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	11,970	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)	61.56	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)	1,528,334	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: 140189 Component CCN: 143978 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/17/2015 3:13 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	115,332	8,995	124,327	0	124,327	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	110,050	8,851	118,901	0	118,901	9.00
10.00	Subtotal (sum of lines 1 through 9)	225,382	17,846	243,228	0	243,228	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	20,239	20,239	0	20,239	15.00
16.00	Transportation (Health Care Staff)	0	374	374	0	374	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	11,809	11,809	0	11,809	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	32,422	32,422	0	32,422	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	225,382	50,268	275,650	0	275,650	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	51,435	51,435	0	51,435	29.00
30.00	Administrative Costs	26,847	3,990	30,837	0	30,837	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	26,847	55,425	82,272	0	82,272	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	252,229	105,693	357,922	0	357,922	32.00

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

Provider CCN: 140189 | Component CCN: 143978 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/17/2015 3:13 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	124,327		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	118,901		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	243,228		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	20,239		15.00
16.00	Transportation (Health Care Staff)	0	374		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	11,809		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	32,422		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	275,650		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	51,435		29.00
30.00	Administrative Costs	0	30,837		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	82,272		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	357,922		32.00

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

Provider CCN: 140189 Component CCN: 143998 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/17/2015 3:13 pm

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	211,566	24,289	235,855	0	235,855	1.00
2.00	Physician Assistant	104,820	8,578	113,398	0	113,398	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	0	0	0	0	0	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	99,787	5,749	105,536	0	105,536	9.00
10.00	Subtotal (sum of lines 1 through 9)	416,173	38,616	454,789	0	454,789	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	30,671	30,671	0	30,671	15.00
16.00	Transportation (Health Care Staff)	0	550	550	0	550	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	25,221	25,221	0	25,221	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	56,442	56,442	0	56,442	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	416,173	95,058	511,231	0	511,231	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	61,729	61,729	0	61,729	29.00
30.00	Administrative Costs	59,130	5,175	64,305	0	64,305	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	59,130	66,904	126,034	0	126,034	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	475,303	161,962	637,265	0	637,265	32.00

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

Provider CCN: 140189 | Component CCN: 143998 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/17/2015 3:13 pm

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	235,855		1.00
2.00	Physician Assistant	0	113,398		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	105,536		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	454,789		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	30,671		15.00
16.00	Transportation (Health Care Staff)	0	550		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	25,221		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	56,442		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	511,231		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	61,729		29.00
30.00	Administrative Costs	0	64,305		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	126,034		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	637,265		32.00

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

Provider CCN: 140189 Component CCN: 143435 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/17/2015 3:13 pm

Rural Health Clinic (RHC) III | 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	251,867	15,228	267,095	0	267,095	1.00
2.00	Physician Assistant	230,049	11,975	242,024	0	242,024	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	0	0	0	0	0	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	128,734	7,188	135,922	0	135,922	9.00
10.00	Subtotal (sum of lines 1 through 9)	610,650	34,391	645,041	0	645,041	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	21,199	21,199	0	21,199	15.00
16.00	Transportation (Health Care Staff)	0	1,914	1,914	0	1,914	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	25,221	25,221	0	25,221	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	48,334	48,334	0	48,334	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	610,650	82,725	693,375	0	693,375	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	40,607	40,607	0	40,607	29.00
30.00	Administrative Costs	61,311	5,248	66,559	0	66,559	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	61,311	45,855	107,166	0	107,166	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	671,961	128,580	800,541	0	800,541	32.00

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

Provider CCN: 140189 | Component CCN: 143435 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/17/2015 3:13 pm

Rural Health Clinic (RHC) III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	267,095		1.00
2.00	Physician Assistant	0	242,024		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		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	135,922		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	645,041		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	21,199		15.00
16.00	Transportation (Health Care Staff)	0	1,914		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	25,221		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	48,334		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	693,375		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	40,607		29.00
30.00	Administrative Costs	0	66,559		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	107,166		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	800,541		32.00

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

Provider CCN: 140189 Component CCN: 148541 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/17/2015 3:13 pm

Rural Health Clinic (RHC) IV | 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	0	0	0	0	0	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	114,892	9,374	124,266	0	124,266	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	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	78,340	7,447	85,787	0	85,787	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	193,232	16,821	210,053	0	210,053	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	30,076	30,076	0	30,076	15.00
16.00	Transportation (Health Care Staff)	0	807	807	0	807	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	10,809	10,809	0	10,809	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	41,692	41,692	0	41,692	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	193,232	58,513	251,745	0	251,745	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	80,648	80,648	0	80,648	29.00
30.00	Administrative Costs	33,401	10,662	44,063	0	44,063	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	33,401	91,310	124,711	0	124,711	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	226,633	149,823	376,456	0	376,456	32.00

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

Provider CCN: 140189 | Component CCN: 148541 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/17/2015 3:13 pm

Rural Health Clinic (RHC) IV | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	0		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	124,266		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	85,787		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	210,053		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	30,076		15.00
16.00	Transportation (Health Care Staff)	0	807		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	10,809		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	41,692		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	251,745		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	80,648		29.00
30.00	Administrative Costs	0	44,063		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	124,711		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	376,456		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140189 | Component CCN: 143978 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-2 | Date/Time Prepared: 11/17/2015 3:13 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	0	0		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	1.00	2,691	2,100	2,100		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.00	2,691		2,100	2,691	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)	1.00	2,691			2,691	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)					275,650	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)					275,650	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)					82,272	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					549,821	15.00
16.00	Total overhead (sum of lines 14 and 15)					632,093	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					632,093	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					632,093	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					907,743	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140189 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-2

Component CCN: 143998 | Date/Time Prepared: 11/17/2015 3:13 pm

Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.00	1,765	2,100	2,100		1.00
2.00	Physician Assistant	1.00	2,387	2,100	2,100		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.00	4,152		4,200	4,200	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)	2.00	4,152			4,200	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)					511,231	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)					511,231	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)					126,034	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					444,531	15.00
16.00	Total overhead (sum of lines 14 and 15)					570,565	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					570,565	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					570,565	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,081,796	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140189 | Component CCN: 143435 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-2 | Date/Time Prepared: 11/17/2015 3:13 pm

Rural Health Clinic (RHC) III | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	1.00	2,251	2,100	2,100		1.00
2.00	Physician Assistant	1.05	4,081	2,100	2,205		2.00
3.00	Nurse Practitioner	0.00	0	0	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.05	6,332		4,305	6,332	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)	2.05	6,332			6,332	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)					693,375	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)					693,375	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)					107,166	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					406,366	15.00
16.00	Total overhead (sum of lines 14 and 15)					513,532	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					513,532	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					513,532	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,206,907	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 140189 | Component CCN: 148541 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-2 | Date/Time Prepared: 11/17/2015 3:13 pm

Rural Health Clinic (RHC) IV | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.00	0	0	0		1.00
2.00	Physician Assistant	0.00	0	0	0		2.00
3.00	Nurse Practitioner	0.74	3,114	2,100	1,554		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.74	3,114		1,554	3,114	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.74	3,114			3,114	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)					251,745	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)					251,745	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)					124,711	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					172,874	15.00
16.00	Total overhead (sum of lines 14 and 15)					297,585	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					297,585	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					297,585	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					549,330	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 140189 | Component CCN: 143978 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-3 | Date/Time Prepared: 11/17/2015 3:13 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		907,743	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		8,256	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		899,487	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,691	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)		2,691	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		334.26	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)	79.80	80.44	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	331	306	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	26,414	24,615	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) *		51,029	16.00
16.01	Total program charges (see instructions)(from contractor's records)		73,347	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		30,705	16.04
16.05	Total program cost (see instructions)		30,705	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		12,648	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		12,140	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		30,705	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		912	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		31,617	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)		31,617	26.00
26.01	Sequestration adjustment (see instructions)		632	26.01
27.00	Interim payments		29,485	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)		1,500	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2014 To 06/30/2015	Worksheet M-3 Date/Time Prepared: 11/17/2015 3:13 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,081,796	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		5,273	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,076,523	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		4,200	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)		4,200	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		256.32	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)	79.80	80.44	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	415	458	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	33,117	36,842	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) *		69,959	16.00
16.01	Total program charges (see instructions)(from contractor's records)		126,872	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		46,711	16.04
16.05	Total program cost (see instructions)		46,711	16.05
17.00	Primary payer amounts		131	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		11,570	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		23,060	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		46,580	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		256	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		46,836	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)		46,836	26.00
26.01	Sequestration adjustment (see instructions)		937	26.01
27.00	Interim payments		44,881	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)		1,018	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2014 To 06/30/2015	Worksheet M-3 Date/Time Prepared: 11/17/2015 3:13 pm
	Title XVIII	Rural Health Clinic (RHC) III	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)	1,206,907	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)	2,400	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	1,204,507	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	6,332	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)	6,332	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)	190.23	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)	79.80	80.44	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	691	785	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	55,142	63,145	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) *		118,287	16.00
16.01	Total program charges (see instructions)(from contractor's records)		204,023	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		76,576	16.04
16.05	Total program cost (see instructions)		76,576	16.05
17.00	Primary payer amounts		309	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		22,567	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		36,291	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		76,267	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		168	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		76,435	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)		76,435	26.00
26.01	Sequestration adjustment (see instructions)		1,529	26.01
27.00	Interim payments		73,180	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)		1,726	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 140189 Component CCN: 148541	Period: From 07/01/2014 To 06/30/2015	Worksheet M-3 Date/Time Prepared: 11/17/2015 3:13 pm
	Title XVIII	Rural Health Clinic (RHC) IV	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)		549,330	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		5,143	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		544,187	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,114	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)		3,114	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		174.75	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)	0.00	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	0.00	80.44	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	792	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	63,708	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) *		63,708	16.00
16.01	Total program charges (see instructions)(from contractor's records)		95,422	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		42,329	16.04
16.05	Total program cost (see instructions)		42,329	16.05
17.00	Primary payer amounts		50	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		10,797	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		16,925	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		42,279	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		199	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		42,478	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)		42,478	26.00
26.01	Sequestration adjustment (see instructions)		850	26.01
27.00	Interim payments		40,917	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)		711	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: 140189 Component CCN: 143978	Period: From 07/01/2014 To 06/30/2015	Worksheet M-4 Date/Time Prepared: 11/17/2015 3:13 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	243,228	243,228	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	670	1,837	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	670	1,837	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	275,650	275,650	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	632,093	632,093	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.002431	0.006664	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,537	4,212	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,207	6,049	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	14	152	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	157.64	39.80	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	2	15	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	315	597	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)		8,256	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)		912	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2014 To 06/30/2015	Worksheet M-4 Date/Time Prepared: 11/17/2015 3:13 pm
	Title XVIII	Rural Health Clinic (RHC) II	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	454,789	454,789	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	475	2,017	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	475	2,017	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	511,231	511,231	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	570,565	570,565	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000929	0.003945	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	530	2,251	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,005	4,268	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	10	167	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	100.50	25.56	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	10	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	256	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)		5,273	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)		256	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2014 To 06/30/2015	Worksheet M-4 Date/Time Prepared: 11/17/2015 3:13 pm
	Title XVIII	Rural Health Clinic (RHC) III	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	645,041	645,041	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	195	1,184	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	195	1,184	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	693,375	693,375	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	513,532	513,532	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000281	0.001708	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	144	877	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	339	2,061	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	4	98	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	84.75	21.03	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	8	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	168	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)		2,400	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)		168	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 140189 Component CCN: 148541	Period: From 07/01/2014 To 06/30/2015	Worksheet M-4 Date/Time Prepared: 11/17/2015 3:13 pm
	Title XVIII	Rural Health Clinic (RHC) IV	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	210,053	210,053	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,210	1,147	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,210	1,147	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	251,745	251,745	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	297,585	297,585	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004806	0.004556	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,430	1,356	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	2,640	2,503	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	22	95	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	120.00	26.35	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	3	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	120	79	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)		5,143	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)		199	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140189 Component CCN: 143978	Period: From 07/01/2014 To 06/30/2015	Worksheet M-5 Date/Time Prepared: 11/17/2015 3:13 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		29,485	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		29,485	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		1,500	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		30,985	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140189 Component CCN: 143998	Period: From 07/01/2014 To 06/30/2015	Worksheet M-5 Date/Time Prepared: 11/17/2015 3:13 pm
		Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		44,881	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		44,881	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		1,018	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		45,899	7.00

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

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 140189 Component CCN: 143435	Period: From 07/01/2014 To 06/30/2015	Worksheet M-5 Date/Time Prepared: 11/17/2015 3:13 pm
		Rural Health Clinic (RHC) III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		73,180	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		73,180	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		1,726	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		74,906	7.00

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

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

Provider CCN: 140189
Component CCN: 148541

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

Worksheet M-5

Date/Time Prepared:
11/17/2015 3:13 pm

Rural Health Clinic (RHC) IV

Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		40,917	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		40,917	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		711	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		41,628	7.00

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