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: 141305	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/25/2015 10:51 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/25/2015 Time: 10:51 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSPITAL ASSOCIATION (141305) 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	-269,247	2,543	181,863	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-188,805	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		47,233		0	10.00
200.00	Total	0	-458,052	49,776	181,863	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/25/2015 8:13 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: SOUTH ADAMS STREET	PO Box: 160			1.00
2.00	City: CARTHAGE	State: IL	Zip Code: 62321-	County: HANCOCK	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	MEMORIAL HOSPITAL ASSOCIATION	141305	99914	1	08/08/2000	N	O	P	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MEMORIAL HOSPITAL	14Z305	99914		08/08/2000	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	BOWEN CLINIC	143456	99914		02/05/1999	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	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.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2015 8:13 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2015 8:13 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/25/2015 8:13 am

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	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:	202,531	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141305	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/25/2015 8:13 am

				1.00	2.00	
	All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)			N		140.00
	1.00	2.00	3.00			
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:	Contractor's Number:			141.00
142.00	Street:	PO Box:				142.00
143.00	City:	State:	Zip Code:			143.00
					1.00	
144.00	Are provider based physicians' costs included in Worksheet A?				Y	144.00
				1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.			N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.			N		146.00
					1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.				N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.				N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.				N	149.00

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

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						235,620	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2013	09/30/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141305	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/25/2015 8:13 am

		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: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/25/2015 8:13 am

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	11/19/2015	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: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/25/2015 8:13 am

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	TERESA	SMITH	41.00
42.00	Enter the employer/company name of the cost report preparer.	MEMORIAL HOSPITAL ASSOCIATION		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	217-357-8564	TSMITH@MHTLC.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/25/2015 8:13 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	11/19/2015			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.		CHIEF FINANCIAL OFFICER		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: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/25/2015 8:13 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	18	6,570	32,784.00	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)		18	6,570	32,784.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		18	6,570	32,784.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	0	0			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		18				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: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/25/2015 8:13 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	638	289	1,281			1.00
2.00	HMO and other (see instructions)	106	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	568	0	680			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	46			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,206	289	2,007			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		165	289			13.00
14.00	Total (see instructions)	1,206	454	2,296	0.00	151.91	14.00
15.00	CAH visits	6,708	4,704	18,431			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	1,609	0	13,656	0.00	15.25	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	167.16	27.00
28.00	Observation Bed Days		92	262			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	43	85			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: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/25/2015 8:13 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	227	115	507	1.00
2.00	HMO and other (see instructions)			37	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	227	115	507	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	0.00				0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RHC (CONSOLIDATED)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141305 Component CCN: 143456 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-8 | Date/Time Prepared: 11/25/2015 8:13 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street		1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		IL		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
9.01		0		9.01
9.02		0		9.02
9.03		0		9.03
9.04		0		9.04
9.05		0		9.05
9.06		0		9.06
9.07		0		9.07
9.08		0		9.08
9.09		0		9.09
9.10		0		9.10

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

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

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

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	BOWEN CLINIC	143456	14.00
14.01		ADAMS STREET CLINIC	143405	14.01
14.02		LAHARPE CLINIC	148534	14.02
14.03		NAUVOO CLINIC	148547	14.03

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

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141305 Component CCN: 143456	Period: From 07/01/2014 To 06/30/2015	Worksheet S-8 Date/Time Prepared: 11/25/2015 8:13 am
		Rural Health Clinic (RHC) I	Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		HANCOCK				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	18:00	08:00	17:00	08:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 11/25/2015 8:13 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.527510	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,987,437	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	1,157,923	5.00
6.00	Medicaid charges	10,329,290	6.00
7.00	Medicaid cost (line 1 times line 6)	5,448,804	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)	2,303,444	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	84,418	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	2,303,444	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	249,228	177,007	426,235	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	131,470	93,373	224,843	21.00
22.00	Partial payment by patients approved for charity care	15,156	11,367	26,523	22.00
23.00	Cost of charity care (line 21 minus line 22)	116,314	82,006	198,320	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)	775,281	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	202,698	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	572,583	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	302,043	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	500,363	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,803,807	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/25/2015 8:13 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1,183,727	1,183,727	-1,156,382	27,345	1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	0	2,197,018	2,197,018	1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB		0	0	25,491	25,491	1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		491,047	491,047	19,128	510,175	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP		0	0	7,078	7,078	2.01
3.00	00300	OTHER CAPITAL RELATED COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	85,545	2,037,575	2,123,120	-57,901	2,065,219	4.00
5.01	00550	ADMINISTRATION & GENERAL	1,536,656	1,900,441	3,437,097	17,109	3,454,206	5.01
7.00	00700	OPERATION OF PLANT	182,801	477,212	660,013	-8,035	651,978	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	8,035	8,035	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	51,494	51,494	0	51,494	8.00
9.00	00900	HOUSEKEEPING	92,851	46,193	139,044	0	139,044	9.00
10.00	01000	DIETARY	148,847	98,124	246,971	-94,400	152,571	10.00
11.00	01100	CAFETERIA	0	0	0	94,400	94,400	11.00
13.00	01300	NURSING ADMINISTRATION	190,315	31,037	221,352	-39,886	181,466	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	139,940	70,756	210,696	0	210,696	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	39,886	39,886	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	397,062	19,368	416,430	0	416,430	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	924,576	70,582	995,158	165,654	1,160,812	30.00
43.00	04300	NURSERY	0	0	0	176,868	176,868	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	357,151	90,550	447,701	0	447,701	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	345,147	47,827	392,974	-342,522	50,452	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	448,844	493,035	941,879	0	941,879	54.00
56.00	05600	RADIOISOTOPE	0	74,037	74,037	0	74,037	56.00
60.00	06000	LABORATORY	539,542	445,399	984,941	0	984,941	60.00
60.02	06002	GEO PSYCH	76,377	167,269	243,646	0	243,646	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	58,896	58,896	0	58,896	62.00
65.00	06500	RESPIRATORY THERAPY	192,514	55,320	247,834	-17,424	230,410	65.00
66.00	06600	PHYSICAL THERAPY	0	86,483	86,483	0	86,483	66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,382	8,382	17,424	25,806	69.00
69.01	06901	PULMONARY REHAB	44,819	127,251	172,070	0	172,070	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,945	633,218	659,163	-75,607	583,556	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	75,607	75,607	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	151,306	630,338	781,644	0	781,644	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,066,467	502,954	1,569,421	-47,799	1,521,622	88.00
90.00	09000	CLINIC	1,820,258	431,398	2,251,656	57,901	2,309,557	90.00
91.00	09100	EMERGENCY	321,715	1,765,767	2,087,482	0	2,087,482	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	62,905	11,463	74,368	0	74,368	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		1,119,502	1,119,502	-1,119,502	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,151,583	13,226,645	22,378,228	-57,859	22,320,369	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	237,685	57,966	295,651	57,859	353,510	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	9,389,268	13,284,611	22,673,879	0	22,673,879	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/25/2015 8:13 am

		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	0	27,345		1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	-24,142	2,172,876		1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	0	25,491		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-91,775	418,400		2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	0	7,078		2.01
3.00	00300	OTHER CAPITAL RELATED COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-92,687	1,972,532		4.00
5.01	00550	ADMINISTRATION & GENERAL	-548,791	2,905,415		5.01
7.00	00700	OPERATION OF PLANT	0	651,978		7.00
7.01	00701	OPERATION OF PLANT MOB	0	8,035		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	51,494		8.00
9.00	00900	HOUSEKEEPING	0	139,044		9.00
10.00	01000	DIETARY	-6,238	146,333		10.00
11.00	01100	CAFETERIA	-27,527	66,873		11.00
13.00	01300	NURSING ADMINISTRATION	0	181,466		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,407	206,289		16.00
17.00	01700	SOCIAL SERVICE	0	39,886		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	416,430		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,160,812		30.00
43.00	04300	NURSERY	0	176,868		43.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	447,701		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	50,452		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-986	940,893		54.00
56.00	05600	RADIOISOTOPE	0	74,037		56.00
60.00	06000	LABORATORY	0	984,941		60.00
60.02	06002	GEO PSYCH	-27,171	216,475		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	58,896		62.00
65.00	06500	RESPIRATORY THERAPY	0	230,410		65.00
66.00	06600	PHYSICAL THERAPY	0	86,483		66.00
69.00	06900	ELECTROCARDIOLOGY	0	25,806		69.00
69.01	06901	PULMONARY REHAB	0	172,070		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	583,556		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	75,607		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	781,644		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-8,607	1,513,015		88.00
90.00	09000	CLINIC	-1,647,369	662,188		90.00
91.00	09100	EMERGENCY	-340,726	1,746,756		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	74,368		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,820,426	19,499,943		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	353,510		192.00
194.00	07950	NAUVOO APARTMENTS	0	0		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-2,820,426	19,853,453		200.00

RECLASSIFICATIONS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/25/2015 8:13 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS DEPRECIATION EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1,128,331	1.00
2.00	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	25,491	2.00
3.00		0.00	0	0	3.00
	TOTALS		0	1,153,822	
	B - TO RECLASS CAFETERIA				
1.00	CAFETERIA	11.00	56,894	37,506	1.00
	TOTALS		56,894	37,506	
	C - TO RECLASS RHC DEPR EXPENSE				
1.00	RURAL HEALTH CLINIC	88.00	0	10,060	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	10,060	
	D - TO RECLASS SOCIAL SERVICES SALARY				
1.00	SOCIAL SERVICE	17.00	39,886	0	1.00
	TOTALS		39,886	0	
	E - TO RECLASS INTEREST				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	33,706	1.00
2.00	ADMINISTRATION & GENERAL	5.01	0	17,109	2.00
3.00	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1,068,687	3.00
	TOTALS		0	1,119,502	
	F - TO RECLASS ACUTE AND NURSERY COSTS				
1.00	ADULTS & PEDIATRICS	30.00	145,493	20,161	1.00
2.00	NURSERY	43.00	155,342	21,526	2.00
	TOTALS		300,835	41,687	
	G - MOB EQUIPMENT DEPRECIATION				
1.00	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	7,078	1.00
	TOTALS		0	7,078	
	H - TO RECLASS EKG TIME				
1.00	ELECTROCARDIOLOGY	69.00	20,046	0	1.00
2.00	RESPIRATORY THERAPY	65.00	0	2,622	2.00
	TOTALS		20,046	2,622	
	I - TO RECLASS NON RHC TIME				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	98,086	0	1.00
	TOTALS		98,086	0	
	K - RECLASS ALLOWABLE PHYSICIAN FICA				
1.00	CLINIC	90.00	0	57,901	1.00
	TOTALS		0	57,901	
	M - IMPLANTABLE SUPPLIES RECLASS				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	75,607	1.00
	TOTALS		0	75,607	
	N - MOB UTILITIES				
1.00	OPERATION OF PLANT MOB	7.01	0	8,035	1.00
	TOTALS		0	8,035	
	O - NAUVOO RHC				
1.00	RURAL HEALTH CLINIC	88.00	30,386	9,841	1.00
	TOTALS		30,386	9,841	
500.00	Grand Total: Increases		546,133	2,523,661	500.00

RECLASSIFICATIONS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/25/2015 8:13 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS DEPRECIATION EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1,153,822	9		1.00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3.00
	TOTALS		0	1,153,822			
	B - TO RECLASS CAFETERIA						
1.00	DIETARY	10.00	56,894	37,506	0		1.00
	TOTALS		56,894	37,506			
	C - TO RECLASS RHC DEPR EXPENSE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	2,560	9		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	7,500	11		2.00
	TOTALS		0	10,060			
	D - TO RECLASS SOCIAL SERVICES SALARY						
1.00	NURSING ADMINISTRATION	13.00	39,886	0	0		1.00
	TOTALS		39,886	0			
	E - TO RECLASS INTEREST						
1.00	INTEREST EXPENSE	113.00	0	1,119,502	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	11		3.00
	TOTALS		0	1,119,502			
	F - TO RECLASS ACUTE AND NURSERY COSTS						
1.00	DELIVERY ROOM & LABOR ROOM	52.00	145,493	20,161	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	155,342	21,526	0		2.00
	TOTALS		300,835	41,687			
	G - MOB EQUIPMENT DEPRECIATION						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	7,078	9		1.00
	TOTALS		0	7,078			
	H - TO RECLASS EKG TIME						
1.00	RESPIRATORY THERAPY	65.00	20,046	0	0		1.00
2.00	ELECTROCARDIOLOGY	69.00	0	2,622	0		2.00
	TOTALS		20,046	2,622			
	I - TO RECLASS NON RHC TIME						
1.00	RURAL HEALTH CLINIC	88.00	98,086	0	0		1.00
	TOTALS		98,086	0			
	K - RECLASS ALLOWABLE PHYSICIAN FICA						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	57,901	0		1.00
	TOTALS		0	57,901			
	M - IMPLANTABLE SUPPLIES RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	75,607	0		1.00
	TOTALS		0	75,607			
	N - MOB UTILITIES						
1.00	OPERATION OF PLANT	7.00	0	8,035	0		1.00
	TOTALS		0	8,035			
	O - NAUVOO RHC						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	30,386	9,841	0		1.00
	TOTALS		30,386	9,841			
500.00	Grand Total: Decreases		546,133	2,523,661			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 11/25/2015 8:13 am

		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	504,757	0	0	0	0	1.00
2.00	Land Improvements	235,269	1,003,695	0	1,003,695	0	2.00
3.00	Buildings and Fixtures	21,269,936	3,565,979	0	3,565,979	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	5,524,382	921,054	0	921,054	186,815	6.00
7.00	HIT designated Assets	1,720,552	265,051	0	265,051	0	7.00
8.00	Subtotal (sum of lines 1-7)	29,254,896	5,755,779	0	5,755,779	186,815	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	29,254,896	5,755,779	0	5,755,779	186,815	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	504,757	0	1.00
2.00	Land Improvements	1,238,964	0	2.00
3.00	Buildings and Fixtures	24,835,915	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	6,258,621	0	6.00
7.00	HIT designated Assets	1,985,603	0	7.00
8.00	Subtotal (sum of lines 1-7)	34,823,860	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	34,823,860	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II Date/Time Prepared: 11/25/2015 8:13 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,183,727	0	0	0	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	0	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	0	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	491,047	0	0	0	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0	0	2.01
3.00	Total (sum of lines 1-2)	1,674,774	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	1,183,727		1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0		1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0		1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	491,047		2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0		2.01
3.00	Total (sum of lines 1-2)	0	1,674,774		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 11/25/2015 8:13 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,238,964	0	1,238,964	0.035578	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	25,339,772	0	25,339,772	0.727655	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	0.000000	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	8,245,124	0	8,245,124	0.236767	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0.000000	0	2.01
3.00	Total (sum of lines 1-2)	34,823,860	0	34,823,860	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	27,345	0	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	0	0	1,121,510	0	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	25,491	0	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	392,194	0	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	7,078	0	2.01
3.00	Total (sum of lines 1-2)	0	0	0	1,573,618	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	27,345	1.00
1.02	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1,051,366	0	0	0	2,172,876	1.02
1.03	CAP REL COSTS-BLDG & FIXT MOB	0	0	0	0	25,491	1.03
2.00	NEW CAP REL COSTS-MVBLE EQUIP	26,206	0	0	0	418,400	2.00
2.01	CAP REL COSTS-MOB MVBLE EQUIP	0	0	0	0	7,078	2.01
3.00	Total (sum of lines 1-2)	1,077,572	0	0	0	2,651,190	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/25/2015 8:13 am

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.02	Investment income - NEW CAP REL COSTS-BLDG & FIXT (NEW B (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	1.02
1.03	Investment income - CAP REL COSTS-BLDG & FIXT MOB (chapter 2)		0	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	1.03
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2.01	Investment income - CAP REL COSTS-MOB MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	2.01
3.00	Investment income - other (chapter 2)	B	-6,821	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	9	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-4,076	ADMINISTRATION & GENERAL	5.01	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,964,753			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	-27,527	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	-4,407	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	-1,562	DIETARY	10.00	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
26.02	Depreciation - NEW CAP REL COSTS-BLDG & FIXT (NEW B		0	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	0	26.02
26.03	Depreciation - CAP REL COSTS-BLDG & FIXT MOB		0	CAP REL COSTS-BLDG & FIXT MOB	1.03	0	26.03

ADJUSTMENTS TO EXPENSES | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/25/2015 8:13 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
27.01	Depreciation - CAP REL COSTS-MOB MVBLE EQUIP		0	CAP REL COSTS-MOB MVBLE EQUIP	2.01	0	27.01
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-91,775	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	RENT INCOME	B	-30,220	CLINIC	90.00	0	33.00
34.00			0		0.00	0	34.00
35.00	IT MISC REVENUE	B	-203	ADMINISTRATION & GENERAL	5.01	0	35.00
36.00	LOBBYING	A	-9,622	ADMINISTRATION & GENERAL	5.01	0	36.00
37.00			0		0.00	0	37.00
38.00	ADVERTISING - LAHARPE	A	-1,203	RURAL HEALTH CLINIC	88.00	0	38.00
39.00	ADVERTISING - HOSPITAL	A	-105,249	ADMINISTRATION & GENERAL	5.01	0	39.00
40.00	ADVERTSING- BOWEN	A	-2,757	RURAL HEALTH CLINIC	88.00	0	40.00
41.00	ADVERTISING - CLINIC	A	-6,218	CLINIC	90.00	0	41.00
42.00	ADVERTISING - WOMENS	A	-4,647	RURAL HEALTH CLINIC	88.00	0	42.00
43.00	PROFESSIONL LIABILITY	A	-65,816	CLINIC	90.00	0	43.00
44.00	UNNECESSARY BORROWING	A	-17,321	NEW CAP REL COSTS-BLDG & FIXT (NEW B	1.02	11	44.00
45.00	CLINIC SALARY REIMBURSEMENT	B	-39,116	CLINIC	90.00	0	45.00
45.01			0		0.00	0	45.01
45.02	RENTAL INCOME - MIDWEST	B	-1,830	CLINIC	90.00	0	45.02
45.03	PROVIDER TAX	A	-335,378	ADMINISTRATION & GENERAL	5.01	0	45.03
45.04	MISC INCOME	B	-3,164	ADMINISTRATION & GENERAL	5.01	0	45.04
45.05	TRAINING INSERVICE	A	-40	ADMINISTRATION & GENERAL	5.01	0	45.05
45.06			0		0.00	0	45.06
45.07			0		0.00	0	45.07
45.08	PURCHASE DISCOUNTS	B	-7,505	ADMINISTRATION & GENERAL	5.01	0	45.08
45.09	RADIOLOGY	B	-986	RADIOLOGY-DIAGNOSTIC	54.00	0	45.09
45.10	MARKETING SALARIES	A	-61,207	ADMINISTRATION & GENERAL	5.01	0	45.10
45.11	MARKETING FRINGES	A	-9,845	ADMINISTRATION & GENERAL	5.01	0	45.11
45.12	CITY OF CARTAGE INTEREST	A	-12,502	ADMINISTRATION & GENERAL	5.01	0	45.12
45.13			0		0.00	0	45.13
45.14			0		0.00	0	45.14
45.15	GEROPSYCH MEALS	B	-4,676	DIETARY	10.00	0	45.15
45.16			0		0.00	0	45.16
45.17			0		0.00	0	45.17
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,820,426				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: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 11/25/2015 8:13 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	24,000	0	24,000	0	0	1.00
2.00	56.00	RADIOISOTOPE	6,000	0	6,000	0	0	2.00
3.00	60.02	GEO PSYCH	27,171	27,171	0	0	0	3.00
4.00	69.01	PULMONARY REHAB	18,000	0	18,000	0	0	4.00
5.00	90.00	CLINIC	1,504,169	1,504,169	0	0	0	5.00
6.00	91.00	EMERGENCY	1,713,915	340,726	1,373,189	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	92,687	92,687	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			3,385,942	1,964,753	1,421,189		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	56.00	RADIOISOTOPE	0	0	0	0	0	2.00
3.00	60.02	GEO PSYCH	0	0	0	0	0	3.00
4.00	69.01	PULMONARY REHAB	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	0		1.00
2.00	56.00	RADIOISOTOPE	0	0	0	0		2.00
3.00	60.02	GEO PSYCH	0	0	0	27,171		3.00
4.00	69.01	PULMONARY REHAB	0	0	0	0		4.00
5.00	90.00	CLINIC	0	0	0	1,504,169		5.00
6.00	91.00	EMERGENCY	0	0	0	340,726		6.00
7.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	92,687		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,964,753		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/25/2015 8:13 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	408.50	0.00	333.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	77.13	0.00	38.57	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.57	38.57	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					31,508	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					31,508	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					12,844	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					44,352	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					77.13	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					60,161	22.00
23.00	Total salary equivalency (see instructions)					73,005	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/25/2015 8:13 am

		Physical Therapy	Cost	
			1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	77.13	0.00	38.57	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	73,005	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	73,005	63.00
64.00	Total cost of outside supplier services (from your records)	59,320	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141305	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2015 8:13 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		0.00	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	95.50	0.00	175.50	0.00	9.00
10.00	AHSEA (see instructions)	0.00	73.10	0.00	36.55	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.55	36.55	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION			
14.00	Supervisors (column 1, line 9 times column 1, line 10)		0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)		6,981	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)		0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)		6,981	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)		6,415	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)		13,396	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.			
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)		73.10	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)		57,018	22.00
23.00	Total salary equivalency (see instructions)		63,433	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE			
	Standard Travel Allowance			
24.00	Therapists (line 3 times column 2, line 11)		0	24.00
25.00	Assistants (line 4 times column 3, line 11)		0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)		0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)		0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)		0	28.00
	Optional Travel Allowance and Optional Travel Expense			
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)		0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)		0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)		0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)		0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)		0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)		0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE			
	Standard Travel Expense			
36.00	Therapists (line 5 times column 2, line 11)		0	36.00
37.00	Assistants (line 6 times column 3, line 11)		0	37.00
38.00	Subtotal (sum of lines 36 and 37)		0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)		0	39.00
	Optional Travel Allowance and Optional Travel Expense			
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)		0	41.00
42.00	Subtotal (sum of lines 40 and 41)		0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.			
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)		0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141305	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2015 8:13 am

		Occupational Therapy	Cost	
			1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		0	46.00

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	73.10	0.00	36.55	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		63,433	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		0	62.00
63.00	Total allowance (sum of lines 57-62)		63,433	63.00
64.00	Total cost of outside supplier services (from your records)		21,680	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		0	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		0	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/25/2015 8:13 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					0.00	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	60.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	70.24	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	35.12	35.12	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					4,250	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					4,250	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					4,250	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					70.25	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					54,795	22.00
23.00	Total salary equivalency (see instructions)					54,795	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					0	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					0	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					0	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					0	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

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Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	70.24	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	54,795	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	0	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	54,795	63.00
64.00	Total cost of outside supplier services (from your records)	5,483	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	0	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	0	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	0	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	0	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/25/2015 8:13 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				NEW BLDG & FIXT	NEW BLDG & FIXT (NEW B	BLDG & FIXT MOB	NEW MVBLE EQUIP	
			0	1.00	1.02	1.03	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	27,345	27,345				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	2,172,876	0	2,172,876			1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	25,491	0	0	25,491		1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	418,400				418,400	2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	7,078				0	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,972,532	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	2,905,415	9,693	521,906	10,151	108,291	5.01
7.00	00700	OPERATION OF PLANT	651,978	1,204	107,691	521	20,360	7.00
7.01	00701	OPERATION OF PLANT MOB	8,035	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	51,494	0	9,324	0	1,503	8.00
9.00	00900	HOUSEKEEPING	139,044	0	23,362	205	3,765	9.00
10.00	01000	DIETARY	146,333	0	44,162	0	7,117	10.00
11.00	01100	CAFETERIA	66,873	0	25,155	0	4,054	11.00
13.00	01300	NURSING ADMINISTRATION	181,466	0	13,577	0	2,188	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	206,289	2,968	40,320	0	13,904	16.00
17.00	01700	SOCIAL SERVICE	39,886	0	8,966	0	1,445	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	416,430	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,160,812	0	501,157	0	80,764	30.00
43.00	04300	NURSERY	176,868	0	11,527	0	1,858	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	447,701	0	205,289	0	33,083	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	50,452	0	45,392	0	7,315	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	940,893	0	226,909	0	36,567	54.00
56.00	05600	RADIOISOTOPE	74,037	0	15,882	0	2,559	56.00
60.00	06000	LABORATORY	984,941	195	86,481	0	14,424	60.00
60.02	06002	GEO PSYCH	216,475	3,299	0	991	8,232	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	58,896	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	230,410	0	35,402	0	5,705	65.00
66.00	06600	PHYSICAL THERAPY	86,483	0	13,269	0	2,138	66.00
69.00	06900	ELECTROCARDIOLOGY	25,806	0	57,637	0	9,288	69.00
69.01	06901	PULMONARY REHAB	172,070	2,756	0	980	6,878	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	583,556	0	16,702	0	2,692	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	75,607	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	781,644	99	64,092	0	10,576	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,513,015	2,280	0	0	5,689	88.00
90.00	09000	CLINIC	662,188	4,212	0	7,856	10,510	90.00
91.00	09100	EMERGENCY	1,746,756	0	94,883	0	15,291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	74,368	639	0	669	1,593	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,499,943	27,345	2,169,085	21,373	417,789	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,791	0	611	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	353,510	0	0	4,118	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	19,853,453	27,345	2,172,876	25,491	418,400	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/25/2015 8:13 am

		Cost Center Description	CAPITAL RELATED COSTS MOB MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			2.01	4.00	4A	5.01	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP	7,078					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,972,532				4.00
5.01	00550	ADMINISTRATION & GENERAL	2,818	376,644	3,934,918	3,934,918		5.01
7.00	00700	OPERATION OF PLANT	145	44,806	826,705	204,354	1,031,059	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	8,035	1,986	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	62,321	15,405	6,230	8.00
9.00	00900	HOUSEKEEPING	57	22,759	189,192	46,767	15,608	9.00
10.00	01000	DIETARY	0	22,539	220,151	54,419	29,505	10.00
11.00	01100	CAFETERIA	0	13,945	110,027	27,198	16,806	11.00
13.00	01300	NURSING ADMINISTRATION	0	36,872	234,103	57,868	9,070	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,301	297,782	73,609	26,938	16.00
17.00	01700	SOCIAL SERVICE	0	9,776	60,073	14,850	5,990	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	97,324	513,754	126,995	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	262,285	2,005,018	495,620	334,821	30.00
43.00	04300	NURSERY	0	38,076	228,329	56,441	7,701	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	87,541	773,614	191,230	137,153	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	10,861	114,020	28,185	30,326	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	110,016	1,314,385	324,904	151,597	54.00
56.00	05600	RADIOISOTOPE	0	0	92,478	22,860	10,611	56.00
60.00	06000	LABORATORY	0	132,247	1,218,288	301,150	57,777	60.00
60.02	06002	GEO PSYCH	275	18,721	247,993	61,302	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	58,896	14,559	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	42,274	313,791	77,566	23,652	65.00
66.00	06600	PHYSICAL THERAPY	0	0	101,890	25,186	8,865	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,913	97,644	24,137	38,507	69.00
69.01	06901	PULMONARY REHAB	272	10,986	193,942	47,941	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	6,359	609,309	150,616	11,158	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	75,607	18,689	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	37,087	893,498	220,865	42,820	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	244,808	1,765,792	436,488	0	88.00
90.00	09000	CLINIC	2,181	138,264	825,211	203,985	0	90.00
91.00	09100	EMERGENCY	0	78,856	1,935,786	478,509	63,391	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	186	15,419	92,874	22,958	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,934	1,897,679	19,415,426	3,826,642	1,028,526	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	4,402	1,088	2,533	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,144	74,853	433,625	107,188	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments			0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,078	1,972,532	19,853,453	3,934,918	1,031,059	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/25/2015 8:13 am

		Cost Center Description	OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	10,021					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	83,956				8.00
9.00	00900	HOUSEKEEPING	139	0	251,706			9.00
10.00	01000	DIETARY	0	0	5,889	309,964		10.00
11.00	01100	CAFETERIA	0	0	3,354	0	157,385	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	1,810	0	5,852	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	11,504	0	9,033	16.00
17.00	01700	SOCIAL SERVICE	0	0	1,195	0	1,221	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	1,996	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	35,496	66,825	309,964	38,298	30.00
43.00	04300	NURSERY	0	0	1,537	0	6,492	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	21,196	27,373	0	12,612	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	6,053	0	1,851	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,873	30,256	0	16,168	54.00
56.00	05600	RADIOISOTOPE	0	0	2,118	0	0	56.00
60.00	06000	LABORATORY	0	135	11,934	0	23,334	60.00
60.02	06002	GEO PSYCH	670	0	7,917	0	4,967	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	164	4,720	0	7,603	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,769	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	7,685	0	883	69.00
69.01	06901	PULMONARY REHAB	663	0	6,790	0	2,352	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2,227	0	1,232	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	8,751	0	3,984	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	546	4,707	0	0	88.00
90.00	09000	CLINIC	5,312	1,688	17,474	0	5,786	90.00
91.00	09100	EMERGENCY	0	10,773	12,652	0	11,357	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	452	0	2,063	0	2,364	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,236	83,871	246,603	309,964	157,385	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	506	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,785	85	4,597	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
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)	10,021	83,956	251,706	309,964	157,385	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/25/2015 8:13 am

		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	308,703					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	418,866				16.00
17.00	01700	SOCIAL SERVICE	0	0	83,329			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	7,047	0	0	649,792		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	135,210	31,403	81,662	0	3,534,317	30.00
43.00	04300	NURSERY	22,920	1,820	0	0	325,240	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	44,524	27,413	0	0	1,235,115	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,536	1,601	0	0	188,572	52.00
53.00	05300	ANESTHESIOLOGY	0	18,425	0	649,792	668,217	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	98,523	0	0	1,949,706	54.00
56.00	05600	RADIOISOTOPE	0	5,207	0	0	133,274	56.00
60.00	06000	LABORATORY	0	101,265	0	0	1,713,883	60.00
60.02	06002	GEO PSYCH	0	4,939	0	0	327,788	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1,210	0	0	74,665	62.00
65.00	06500	RESPIRATORY THERAPY	26,841	8,580	0	0	462,917	65.00
66.00	06600	PHYSICAL THERAPY	0	2,774	0	0	140,484	66.00
69.00	06900	ELECTROCARDIOLOGY	3,119	4,859	0	0	176,834	69.00
69.01	06901	PULMONARY REHAB	0	3,514	0	0	255,202	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	11,901	0	0	786,443	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,662	0	0	95,958	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,064	20,944	0	0	1,204,926	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	36,011	0	0	2,243,544	88.00
90.00	09000	CLINIC	0	5,697	0	0	1,065,153	90.00
91.00	09100	EMERGENCY	40,096	27,122	1,667	0	2,581,353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	8,346	395	0	0	129,452	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	308,703	415,265	83,329	649,792	19,293,043	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	8,529	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,601	0	0	551,881	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	308,703	418,866	83,329	649,792	19,853,453	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/25/2015 8:13 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	ADMINISTRATION & GENERAL				5.01
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT MOB				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,534,317		30.00
43.00	04300	NURSERY	0	325,240		43.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	1,235,115		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	188,572		52.00
53.00	05300	ANESTHESIOLOGY	0	668,217		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,949,706		54.00
56.00	05600	RADIOISOTOPE	0	133,274		56.00
60.00	06000	LABORATORY	0	1,713,883		60.00
60.02	06002	GEO PSYCH	0	327,788		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	74,665		62.00
65.00	06500	RESPIRATORY THERAPY	0	462,917		65.00
66.00	06600	PHYSICAL THERAPY	0	140,484		66.00
69.00	06900	ELECTROCARDIOLOGY	0	176,834		69.00
69.01	06901	PULMONARY REHAB	0	255,202		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	786,443		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	95,958		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,204,926		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,243,544		88.00
90.00	09000	CLINIC	0	1,065,153		90.00
91.00	09100	EMERGENCY	0	2,581,353		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	129,452		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	19,293,043		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,529		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	551,881		192.00
194.00	07950	NAUVOO APARTMENTS	0	0		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	19,853,453		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/25/2015 8:13 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	NEW BLDG & FIXT (NEW B	BLDG & FIXT MOB	NEW MVBLE EQUIP	
			0	1.00	1.02	1.03	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	0	9,693	521,906	10,151	108,291	5.01
7.00	00700	OPERATION OF PLANT	0	1,204	107,691	521	20,360	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	9,324	0	1,503	8.00
9.00	00900	HOUSEKEEPING	0	0	23,362	205	3,765	9.00
10.00	01000	DIETARY	0	0	44,162	0	7,117	10.00
11.00	01100	CAFETERIA	0	0	25,155	0	4,054	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	13,577	0	2,188	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,968	40,320	0	13,904	16.00
17.00	01700	SOCIAL SERVICE	0	0	8,966	0	1,445	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	501,157	0	80,764	30.00
43.00	04300	NURSERY	0	0	11,527	0	1,858	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	205,289	0	33,083	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	45,392	0	7,315	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	226,909	0	36,567	54.00
56.00	05600	RADIOISOTOPE	0	0	15,882	0	2,559	56.00
60.00	06000	LABORATORY	0	195	86,481	0	14,424	60.00
60.02	06002	GEO PSYCH	0	3,299	0	991	8,232	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	35,402	0	5,705	65.00
66.00	06600	PHYSICAL THERAPY	0	0	13,269	0	2,138	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	57,637	0	9,288	69.00
69.01	06901	PULMONARY REHAB	0	2,756	0	980	6,878	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	16,702	0	2,692	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	99	64,092	0	10,576	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,280	0	0	5,689	88.00
90.00	09000	CLINIC	0	4,212	0	7,856	10,510	90.00
91.00	09100	EMERGENCY	0	0	94,883	0	15,291	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	639	0	669	1,593	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	27,345	2,169,085	21,373	417,789	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,791	0	611	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	4,118	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	27,345	2,172,876	25,491	418,400	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/25/2015 8:13 am

		Cost Center Description	CAPITAL RELATED COSTS MOB MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATION & GENERAL	OPERATION OF PLANT	
			2.01	2A	4.00	5.01	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0			4.00
5.01	00550	ADMINISTRATION & GENERAL	2,818	652,859	0	652,859		5.01
7.00	00700	OPERATION OF PLANT	145	129,921	0	33,906	163,827	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	330	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	10,827	0	2,556	990	8.00
9.00	00900	HOUSEKEEPING	57	27,389	0	7,759	2,480	9.00
10.00	01000	DIETARY	0	51,279	0	9,029	4,688	10.00
11.00	01100	CAFETERIA	0	29,209	0	4,513	2,670	11.00
13.00	01300	NURSING ADMINISTRATION	0	15,765	0	9,601	1,441	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	57,192	0	12,213	4,280	16.00
17.00	01700	SOCIAL SERVICE	0	10,411	0	2,464	952	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	21,071	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	581,921	0	82,222	53,201	30.00
43.00	04300	NURSERY	0	13,385	0	9,364	1,224	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	238,372	0	31,728	21,792	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52,707	0	4,676	4,819	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	263,476	0	53,907	24,088	54.00
56.00	05600	RADIOISOTOPE	0	18,441	0	3,793	1,686	56.00
60.00	06000	LABORATORY	0	101,100	0	49,966	9,180	60.00
60.02	06002	GEO PSYCH	275	12,797	0	10,171	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	2,416	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	41,107	0	12,870	3,758	65.00
66.00	06600	PHYSICAL THERAPY	0	15,407	0	4,179	1,409	66.00
69.00	06900	ELECTROCARDIOLOGY	0	66,925	0	4,005	6,118	69.00
69.01	06901	PULMONARY REHAB	272	10,886	0	7,954	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	19,394	0	24,990	1,773	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,101	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	74,767	0	36,645	6,804	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,969	0	72,420	0	88.00
90.00	09000	CLINIC	2,181	24,759	0	33,844	0	90.00
91.00	09100	EMERGENCY	0	110,174	0	79,392	10,072	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	186	3,087	0	3,809	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,934	2,641,526	0	634,894	163,425	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,402	0	181	402	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,144	5,262	0	17,784	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	7,078	2,651,190	0	652,859	163,827	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/25/2015 8:13 am

		Cost Center Description	OPERATION OF PLANT MOB	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB	330					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	14,373				8.00
9.00	00900	HOUSEKEEPING	5	0	37,633			9.00
10.00	01000	DIETARY	0	0	880	65,876		10.00
11.00	01100	CAFETERIA	0	0	501	0	36,893	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	271	0	1,372	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	1,720	0	2,117	16.00
17.00	01700	SOCIAL SERVICE	0	0	179	0	286	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	468	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	6,076	9,989	65,876	8,979	30.00
43.00	04300	NURSERY	0	0	230	0	1,522	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,629	4,093	0	2,956	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	905	0	434	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,375	4,524	0	3,790	54.00
56.00	05600	RADIOISOTOPE	0	0	317	0	0	56.00
60.00	06000	LABORATORY	0	23	1,784	0	5,470	60.00
60.02	06002	GEO PSYCH	22	0	1,184	0	1,164	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	28	706	0	1,782	65.00
66.00	06600	PHYSICAL THERAPY	0	0	265	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,149	0	207	69.00
69.01	06901	PULMONARY REHAB	22	0	1,015	0	551	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	333	0	289	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,308	0	934	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	94	704	0	0	88.00
90.00	09000	CLINIC	174	289	2,613	0	1,356	90.00
91.00	09100	EMERGENCY	0	1,844	1,892	0	2,662	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	15	0	308	0	554	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	238	14,358	36,870	65,876	36,893	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	76	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	92	15	687	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
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)	330	14,373	37,633	65,876	36,893	202.00

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		Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	
			13.00	16.00	17.00	19.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	28,450					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	77,522				16.00
17.00	01700	SOCIAL SERVICE	0	0	14,292			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	649	0	0	22,188		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,463	5,811	14,006		840,544	30.00
43.00	04300	NURSERY	2,112	337	0		28,174	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,103	5,073	0		311,746	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	602	296	0		64,439	52.00
53.00	05300	ANESTHESIOLOGY	0	3,410	0		3,410	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,231	0		370,391	54.00
56.00	05600	RADIOISOTOPE	0	964	0		25,201	56.00
60.00	06000	LABORATORY	0	18,750	0		186,273	60.00
60.02	06002	GEO PSYCH	0	914	0		26,252	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	224	0		2,640	62.00
65.00	06500	RESPIRATORY THERAPY	2,474	1,588	0		64,313	65.00
66.00	06600	PHYSICAL THERAPY	0	513	0		21,773	66.00
69.00	06900	ELECTROCARDIOLOGY	287	899	0		79,590	69.00
69.01	06901	PULMONARY REHAB	0	650	0		21,078	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,202	0		48,981	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	308	0		3,409	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,296	3,876	0		125,630	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,664	0		87,851	88.00
90.00	09000	CLINIC	0	1,054	0		64,089	90.00
91.00	09100	EMERGENCY	3,695	5,019	286		215,036	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		0	93.00
93.01	04950	DIABETIC EDUCATION	769	73	0		8,615	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0		0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,450	76,856	14,292	0	2,599,435	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		5,061	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	666	0		24,506	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0		0	194.00
194.02	07951	BEAUTY SHOP	0	0	0		0	194.02
200.00		Cross Foot Adjustments				22,188	22,188	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	28,450	77,522	14,292	22,188	2,651,190	202.00

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		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB				1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	ADMINISTRATION & GENERAL				5.01
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT MOB				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	840,544		30.00
43.00	04300	NURSERY	0	28,174		43.00
46.00	04600	OTHER LONG TERM CARE	0	0		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	311,746		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	64,439		52.00
53.00	05300	ANESTHESIOLOGY	0	3,410		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	370,391		54.00
56.00	05600	RADIOISOTOPE	0	25,201		56.00
60.00	06000	LABORATORY	0	186,273		60.00
60.02	06002	GEO PSYCH	0	26,252		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	2,640		62.00
65.00	06500	RESPIRATORY THERAPY	0	64,313		65.00
66.00	06600	PHYSICAL THERAPY	0	21,773		66.00
69.00	06900	ELECTROCARDIOLOGY	0	79,590		69.00
69.01	06901	PULMONARY REHAB	0	21,078		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48,981		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,409		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	125,630		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	87,851		88.00
90.00	09000	CLINIC	0	64,089		90.00
91.00	09100	EMERGENCY	0	215,036		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	8,615		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,599,435		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5,061		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	24,506		192.00
194.00	07950	NAUVOO APARTMENTS	0	0		194.00
194.02	07951	BEAUTY SHOP	0	0		194.02
200.00		Cross Foot Adjustments	0	22,188		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	2,651,190		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/25/2015 8:13 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (WFMG/ADMIN SQUARE FEET)	NEW BLDG & FIXT (NEW B (NEW HOSP SQUARE FE)	BLDG & FIXT MOB (MOB SQUARE FEET)	NEW MVBLE EQUIP (HOSP/WFMG/ADMIN SQUARE FEET)	MOB MVBLE EQUIP (MOB SQUARE FEET)	
			1.00	1.02	1.03	2.00	2.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	8,264					1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B	0	42,412				1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB	0	0	25,000			1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP				50,676		2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP				0	25,000	2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00550	ADMINISTRATION & GENERAL	2,929	10,187	9,955	13,116	9,955	5.01
7.00	00700	OPERATION OF PLANT	364	2,102	511	2,466	511	7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	182	0	182	0	8.00
9.00	00900	HOUSEKEEPING	0	456	201	456	201	9.00
10.00	01000	DIETARY	0	862	0	862	0	10.00
11.00	01100	CAFETERIA	0	491	0	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	265	0	265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	897	787	0	1,684	0	16.00
17.00	01700	SOCIAL SERVICE	0	175	0	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	9,782	0	9,782	0	30.00
43.00	04300	NURSERY	0	225	0	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	4,007	0	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	886	0	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,429	0	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	310	0	310	0	56.00
60.00	06000	LABORATORY	59	1,688	0	1,747	0	60.00
60.02	06002	GEO PSYCH	997	0	972	997	972	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	691	0	691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	259	0	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,125	0	1,125	0	69.00
69.01	06901	PULMONARY REHAB	833	0	961	833	961	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	326	0	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30	1,251	0	1,281	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	689	0	0	689	0	88.00
90.00	09000	CLINIC	1,273	0	7,705	1,273	7,705	90.00
91.00	09100	EMERGENCY	0	1,852	0	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	193	0	656	193	656	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,264	42,338	20,961	50,602	20,961	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	4,039	0	4,039	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
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)	27,345	2,172,876	25,491	418,400	7,078	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.308930	51.232576	1.019640	8.256374	0.283120	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)						204.00
205.00		Unit cost multiplier (Wkst. B, Part II)						205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/25/2015 8:13 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT (SALARIES)	Reconciliation	ADMINISTRATION & GENERAL (ACCUM. COST)	OPERATION OF PLANT (HOSP ONLY SQUARE FT)	OPERATION OF PLANT MOB (MOB SQUARE FEET)	
			4.00	5A.01	5.01	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,047,554					4.00
5.01	00550	ADMINISTRATION & GENERAL	1,536,656	-3,934,918	15,918,535			5.01
7.00	00700	OPERATION OF PLANT	182,801	0	826,705	30,123		7.00
7.01	00701	OPERATION OF PLANT MOB	0	0	8,035	0	14,534	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	62,321	182	0	8.00
9.00	00900	HOUSEKEEPING	92,851	0	189,192	456	201	9.00
10.00	01000	DIETARY	91,953	0	220,151	862	0	10.00
11.00	01100	CAFETERIA	56,894	0	110,027	491	0	11.00
13.00	01300	NURSING ADMINISTRATION	150,429	0	234,103	265	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	139,940	0	297,782	787	0	16.00
17.00	01700	SOCIAL SERVICE	39,886	0	60,073	175	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	397,062	0	513,754	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,070,069	0	2,005,018	9,782	0	30.00
43.00	04300	NURSERY	155,342	0	228,329	225	0	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	357,151	0	773,614	4,007	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	44,312	0	114,020	886	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	448,844	0	1,314,385	4,429	0	54.00
56.00	05600	RADIOISOTOPE	0	0	92,478	310	0	56.00
60.00	06000	LABORATORY	539,542	0	1,218,288	1,688	0	60.00
60.02	06002	GEO PSYCH	76,377	0	247,993	0	972	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	58,896	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	172,468	0	313,791	691	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	101,890	259	0	66.00
69.00	06900	ELECTROCARDIOLOGY	20,046	0	97,644	1,125	0	69.00
69.01	06901	PULMONARY REHAB	44,819	0	193,942	0	961	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	25,945	0	609,309	326	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	75,607	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	151,306	0	893,498	1,251	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	998,767	0	1,765,792	0	0	88.00
90.00	09000	CLINIC	564,089	0	825,211	0	7,705	90.00
91.00	09100	EMERGENCY	321,715	0	1,935,786	1,852	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	62,905	0	92,874	0	656	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	7,742,169	-3,934,918	15,480,508	30,049	10,495	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	4,402	74	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	305,385	0	433,625	0	4,039	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,972,532		3,934,918	1,031,059	10,021	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.245110		0.247191	34.228297	0.689487	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0		652,859	163,827	330	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000		0.041013	5.438602	0.022705	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/25/2015 8:13 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (NEW HOSP, WFMG/ADMIN, MOB SQFT)	DIETARY (HOSP PATIENT DAYS)	CAFETERIA (HOURS OF SERVICE)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B						1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB						1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP						2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	ADMINISTRATION & GENERAL						5.01
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT MOB						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	84,993					8.00
9.00	00900	HOUSEKEEPING	0	36,846				9.00
10.00	01000	DIETARY	0	862	2,007			10.00
11.00	01100	CAFETERIA	0	491	0	167,634		11.00
13.00	01300	NURSING ADMINISTRATION	0	265	0	6,233	93,136	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,684	0	9,621	0	16.00
17.00	01700	SOCIAL SERVICE	0	175	0	1,300	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	2,126	2,126	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,934	9,782	2,007	40,793	40,793	30.00
43.00	04300	NURSERY	0	225	0	6,915	6,915	43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,458	4,007	0	13,433	13,433	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	886	0	1,972	1,972	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,044	4,429	0	17,221	0	54.00
56.00	05600	RADIOISOTOPE	0	310	0	0	0	56.00
60.00	06000	LABORATORY	137	1,747	0	24,853	0	60.00
60.02	06002	GEO PSYCH	0	1,159	0	5,290	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	166	691	0	8,098	8,098	65.00
66.00	06600	PHYSICAL THERAPY	0	259	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,125	0	941	941	69.00
69.01	06901	PULMONARY REHAB	0	994	0	2,505	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	326	0	1,312	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,281	0	4,243	4,243	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	553	689	0	0	0	88.00
90.00	09000	CLINIC	1,709	2,558	0	6,163	0	90.00
91.00	09100	EMERGENCY	10,906	1,852	0	12,097	12,097	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	302	0	2,518	2,518	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	84,907	36,099	2,007	167,634	93,136	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	86	673	0	0	0	192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0	0	0	194.00
194.02	07951	BEAUTY SHOP	0	0	0	0	0	194.02
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)	83,956	251,706	309,964	157,385	308,703	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.987799	6.831298	154.441455	0.938861	3.314540	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	14,373	37,633	65,876	36,893	28,450	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.169108	1.021359	32.823119	0.220081	0.305467	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/25/2015 8:13 am

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS REVENUES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
1.02	00102	NEW CAP REL COSTS-BLDG & FIXT (NEW B					1.02
1.03	00103	CAP REL COSTS-BLDG & FIXT MOB					1.03
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
2.01	00201	CAP REL COSTS-MOB MVBLE EQUIP					2.01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00550	ADMINISTRATION & GENERAL					5.01
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT MOB					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	36,890,974				16.00
17.00	01700	SOCIAL SERVICE	0	100			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	2,080		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,765,789	98	0		30.00
43.00	04300	NURSERY	160,299	0	0		43.00
46.00	04600	OTHER LONG TERM CARE	0	0	0		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,414,385	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	141,010	0	0		52.00
53.00	05300	ANESTHESIOLOGY	1,622,813	0	2,080		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,677,384	0	0		54.00
56.00	05600	RADIOISOTOPE	458,640	0	0		56.00
60.00	06000	LABORATORY	8,918,202	0	0		60.00
60.02	06002	GEO PSYCH	435,011	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	106,599	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	755,692	0	0		65.00
66.00	06600	PHYSICAL THERAPY	244,285	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	427,959	0	0		69.00
69.01	06901	PULMONARY REHAB	309,471	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,048,161	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	146,388	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,844,635	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	3,171,668	0	0		88.00
90.00	09000	CLINIC	501,793	0	0		90.00
91.00	09100	EMERGENCY	2,388,795	2	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.01	04950	DIABETIC EDUCATION	34,833	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	36,573,812	100	2,080		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	317,162	0	0		192.00
194.00	07950	NAUVOO APARTMENTS	0	0	0		194.00
194.02	07951	BEAUTY SHOP	0	0	0		194.02
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)	418,866	83,329	649,792		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.011354	833.290000	312.400000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	77,522	14,292	22,188		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002101	142.920000	10.667308		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,534,317		3,534,317	0	0	30.00
43.00	04300	NURSERY	325,240		325,240	0	0	43.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,235,115		1,235,115	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	188,572		188,572	0	0	52.00
53.00	05300	ANESTHESIOLOGY	668,217		668,217	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,949,706		1,949,706	0	0	54.00
56.00	05600	RADIOISOTOPE	133,274		133,274	0	0	56.00
60.00	06000	LABORATORY	1,713,883		1,713,883	0	0	60.00
60.02	06002	GEO PSYCH	327,788		327,788	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	74,665		74,665	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	462,917	0	462,917	0	0	65.00
66.00	06600	PHYSICAL THERAPY	140,484	0	140,484	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	176,834		176,834	0	0	69.00
69.01	06901	PULMONARY REHAB	255,202		255,202	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	786,443		786,443	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95,958		95,958	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,204,926		1,204,926	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,243,544		2,243,544	0	0	88.00
90.00	09000	CLINIC	1,065,153		1,065,153	0	0	90.00
91.00	09100	EMERGENCY	2,581,353		2,581,353	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	415,807		415,807		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	129,452		129,452	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,708,850	0	19,708,850	0	0	200.00
201.00		Less Observation Beds	415,807		415,807		0	201.00
202.00		Total (see instructions)	19,293,043	0	19,293,043	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,151,945		2,151,945			30.00
43.00	04300	NURSERY	160,299		160,299			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	806,971	1,607,414	2,414,385	0.511565	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	140,889	121	141,010	1.337295	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	514,926	1,107,887	1,622,813	0.411765	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	618,922	8,058,462	8,677,384	0.224688	0.000000	54.00
56.00	05600	RADIOISOTOPE	9,847	448,793	458,640	0.290585	0.000000	56.00
60.00	06000	LABORATORY	886,389	8,031,813	8,918,202	0.192178	0.000000	60.00
60.02	06002	GEO PSYCH	0	435,011	435,011	0.753517	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	43,233	63,366	106,599	0.700429	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	222,836	532,856	755,692	0.612574	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	237,309	6,976	244,285	0.575082	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	38,027	389,932	427,959	0.413203	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	309,471	309,471	0.824639	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	709,850	338,311	1,048,161	0.750307	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,000	121,388	146,388	0.655505	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	491,492	1,353,143	1,844,635	0.653206	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,171,668	3,171,668			88.00
90.00	09000	CLINIC	0	501,793	501,793	2.122694	0.000000	90.00
91.00	09100	EMERGENCY	15,983	2,372,812	2,388,795	1.080609	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,872	608,972	613,844	0.677382	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	34,833	34,833	3.716361	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,078,790	29,495,022	36,573,812			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,078,790	29,495,022	36,573,812			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
60.02	06002	GEO PSYCH	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	PULMONARY REHAB	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/25/2015 8:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	Costs RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,534,317		3,534,317	0	3,534,317	30.00
43.00	04300	NURSERY	325,240		325,240	0	325,240	43.00
46.00	04600	OTHER LONG TERM CARE	0		0	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,235,115		1,235,115	0	1,235,115	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	188,572		188,572	0	188,572	52.00
53.00	05300	ANESTHESIOLOGY	668,217		668,217	0	668,217	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,949,706		1,949,706	0	1,949,706	54.00
56.00	05600	RADIOISOTOPE	133,274		133,274	0	133,274	56.00
60.00	06000	LABORATORY	1,713,883		1,713,883	0	1,713,883	60.00
60.02	06002	GEO PSYCH	327,788		327,788	0	327,788	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	74,665		74,665	0	74,665	62.00
65.00	06500	RESPIRATORY THERAPY	462,917	0	462,917	0	462,917	65.00
66.00	06600	PHYSICAL THERAPY	140,484	0	140,484	0	140,484	66.00
69.00	06900	ELECTROCARDIOLOGY	176,834		176,834	0	176,834	69.00
69.01	06901	PULMONARY REHAB	255,202		255,202	0	255,202	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	786,443		786,443	0	786,443	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95,958		95,958	0	95,958	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,204,926		1,204,926	0	1,204,926	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,243,544		2,243,544	0	2,243,544	88.00
90.00	09000	CLINIC	1,065,153		1,065,153	0	1,065,153	90.00
91.00	09100	EMERGENCY	2,581,353		2,581,353	0	2,581,353	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	415,807		415,807		415,807	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0		0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	129,452		129,452	0	129,452	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	19,708,850	0	19,708,850	0	19,708,850	200.00
201.00		Less Observation Beds	415,807		415,807		415,807	201.00
202.00		Total (see instructions)	19,293,043	0	19,293,043	0	19,293,043	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/25/2015 8:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,151,945		2,151,945			30.00
43.00	04300	NURSERY	160,299		160,299			43.00
46.00	04600	OTHER LONG TERM CARE	0		0			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	806,971	1,607,414	2,414,385	0.511565	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	140,889	121	141,010	1.337295	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	514,926	1,107,887	1,622,813	0.411765	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	618,922	8,058,462	8,677,384	0.224688	0.000000	54.00
56.00	05600	RADIOISOTOPE	9,847	448,793	458,640	0.290585	0.000000	56.00
60.00	06000	LABORATORY	886,389	8,031,813	8,918,202	0.192178	0.000000	60.00
60.02	06002	GEO PSYCH	0	435,011	435,011	0.753517	0.000000	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	43,233	63,366	106,599	0.700429	0.000000	62.00
65.00	06500	RESPIRATORY THERAPY	222,836	532,856	755,692	0.612574	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	237,309	6,976	244,285	0.575082	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	38,027	389,932	427,959	0.413203	0.000000	69.00
69.01	06901	PULMONARY REHAB	0	309,471	309,471	0.824639	0.000000	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	709,850	338,311	1,048,161	0.750307	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,000	121,388	146,388	0.655505	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	491,492	1,353,143	1,844,635	0.653206	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,171,668	3,171,668	0.707370	0.000000	88.00
90.00	09000	CLINIC	0	501,793	501,793	2.122694	0.000000	90.00
91.00	09100	EMERGENCY	15,983	2,372,812	2,388,795	1.080609	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	4,872	608,972	613,844	0.677382	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0.000000	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	0	34,833	34,833	3.716361	0.000000	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	7,078,790	29,495,022	36,573,812			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	7,078,790	29,495,022	36,573,812			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/25/2015 8:13 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
43.00	04300	NURSERY		43.00
46.00	04600	OTHER LONG TERM CARE		46.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.511565	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.337295	52.00
53.00	05300	ANESTHESIOLOGY	0.411765	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.224688	54.00
56.00	05600	RADIOISOTOPE	0.290585	56.00
60.00	06000	LABORATORY	0.192178	60.00
60.02	06002	GEO PSYCH	0.753517	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.700429	62.00
65.00	06500	RESPIRATORY THERAPY	0.612574	65.00
66.00	06600	PHYSICAL THERAPY	0.575082	66.00
69.00	06900	ELECTROCARDIOLOGY	0.413203	69.00
69.01	06901	PULMONARY REHAB	0.824639	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.750307	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.655505	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.653206	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.707370	88.00
90.00	09000	CLINIC	2.122694	90.00
91.00	09100	EMERGENCY	1.080609	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.677382	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	93.00
93.01	04950	DIABETIC EDUCATION	3.716361	93.01
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

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

Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part II Date/Time Prepared: 11/25/2015 8:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,235,115	311,746	923,369	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	188,572	64,439	124,133	0	0	52.00
53.00	05300	ANESTHESIOLOGY	668,217	3,410	664,807	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,949,706	370,391	1,579,315	0	0	54.00
56.00	05600	RADIOISOTOPE	133,274	25,201	108,073	0	0	56.00
60.00	06000	LABORATORY	1,713,883	186,273	1,527,610	0	0	60.00
60.02	06002	GEO PSYCH	327,788	26,252	301,536	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	74,665	2,640	72,025	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	462,917	64,313	398,604	0	0	65.00
66.00	06600	PHYSICAL THERAPY	140,484	21,773	118,711	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	176,834	79,590	97,244	0	0	69.00
69.01	06901	PULMONARY REHAB	255,202	21,078	234,124	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	786,443	48,981	737,462	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95,958	3,409	92,549	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,204,926	125,630	1,079,296	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,243,544	87,851	2,155,693	0	0	88.00
90.00	09000	CLINIC	1,065,153	64,089	1,001,064	0	0	90.00
91.00	09100	EMERGENCY	2,581,353	215,036	2,366,317	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	415,807	142,723	273,084	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	129,452	8,615	120,837	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	15,849,293	1,873,440	13,975,853	0	0	200.00
201.00		Less Observation Beds	415,807	142,723	273,084	0	0	201.00
202.00		Total (line 200 minus line 201)	15,433,486	1,730,717	13,702,769	0	0	202.00

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

Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part II Date/Time Prepared: 11/25/2015 8:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1,235,115	2,414,385	0.511565		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	188,572	141,010	1.337295		52.00
53.00	05300	ANESTHESIOLOGY	668,217	1,622,813	0.411765		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,949,706	8,677,384	0.224688		54.00
56.00	05600	RADIOISOTOPE	133,274	458,640	0.290585		56.00
60.00	06000	LABORATORY	1,713,883	8,918,202	0.192178		60.00
60.02	06002	GEO PSYCH	327,788	435,011	0.753517		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	74,665	106,599	0.700429		62.00
65.00	06500	RESPIRATORY THERAPY	462,917	755,692	0.612574		65.00
66.00	06600	PHYSICAL THERAPY	140,484	244,285	0.575082		66.00
69.00	06900	ELECTROCARDIOLOGY	176,834	427,959	0.413203		69.00
69.01	06901	PULMONARY REHAB	255,202	309,471	0.824639		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	786,443	1,048,161	0.750307		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	95,958	146,388	0.655505		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,204,926	1,844,635	0.653206		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,243,544	3,171,668	0.707370		88.00
90.00	09000	CLINIC	1,065,153	501,793	2.122694		90.00
91.00	09100	EMERGENCY	2,581,353	2,388,795	1.080609		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	415,807	613,844	0.677382		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000		93.00
93.01	04950	DIABETIC EDUCATION	129,452	34,833	3.716361		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0	0	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (sum of lines 50 thru 199)	15,849,293	34,261,568			200.00
201.00		Less Observation Beds	415,807	0			201.00
202.00		Total (line 200 minus line 201)	15,433,486	34,261,568			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	311,746	2,414,385	0.129120	105,462	13,617	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	64,439	141,010	0.456982	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,410	1,622,813	0.002101	57,040	120	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	370,391	8,677,384	0.042685	338,416	14,445	54.00
56.00	05600	RADIOISOTOPE	25,201	458,640	0.054947	7,670	421	56.00
60.00	06000	LABORATORY	186,273	8,918,202	0.020887	259,018	5,410	60.00
60.02	06002	GEO PSYCH	26,252	435,011	0.060348	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,640	106,599	0.024766	15,859	393	62.00
65.00	06500	RESPIRATORY THERAPY	64,313	755,692	0.085105	101,865	8,669	65.00
66.00	06600	PHYSICAL THERAPY	21,773	244,285	0.089130	33,248	2,963	66.00
69.00	06900	ELECTROCARDIOLOGY	79,590	427,959	0.185976	15,262	2,838	69.00
69.01	06901	PULMONARY REHAB	21,078	309,471	0.068110	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,981	1,048,161	0.046730	186,035	8,693	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,409	146,388	0.023287	24,568	572	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	125,630	1,844,635	0.068106	155,984	10,623	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	87,851	3,171,668	0.027699	0	0	88.00
90.00	09000	CLINIC	64,089	501,793	0.127720	0	0	90.00
91.00	09100	EMERGENCY	215,036	2,388,795	0.090019	173	16	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	142,723	613,844	0.232507	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	8,615	34,833	0.247323	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,873,440	34,261,568		1,300,600	68,780	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	649,792	0	0	0	649,792	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	649,792	0	0	0	649,792	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,414,385	0.000000	0.000000	105,462	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	141,010	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,622,813	0.400411	0.000000	57,040	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,677,384	0.000000	0.000000	338,416	54.00
56.00	05600	RADIOISOTOPE	0	458,640	0.000000	0.000000	7,670	56.00
60.00	06000	LABORATORY	0	8,918,202	0.000000	0.000000	259,018	60.00
60.02	06002	GEO PSYCH	0	435,011	0.000000	0.000000	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	106,599	0.000000	0.000000	15,859	62.00
65.00	06500	RESPIRATORY THERAPY	0	755,692	0.000000	0.000000	101,865	65.00
66.00	06600	PHYSICAL THERAPY	0	244,285	0.000000	0.000000	33,248	66.00
69.00	06900	ELECTROCARDIOLOGY	0	427,959	0.000000	0.000000	15,262	69.00
69.01	06901	PULMONARY REHAB	0	309,471	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,048,161	0.000000	0.000000	186,035	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	146,388	0.000000	0.000000	24,568	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,844,635	0.000000	0.000000	155,984	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,171,668	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	501,793	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	2,388,795	0.000000	0.000000	173	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	613,844	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
93.01	04950	DIABETIC EDUCATION	0	34,833	0.000000	0.000000	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	34,261,568			1,300,600	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	22,839	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
60.02	06002	GEO PSYCH	0	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	22,839	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.511565	0	439,952	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.337295	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.411765	0	316,479	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.224688	0	2,759,336	0	0	54.00
56.00	05600	RADIOISOTOPE	0.290585	0	215,729	0	0	56.00
60.00	06000	LABORATORY	0.192178	0	2,827,585	0	0	60.00
60.02	06002	GEO PSYCH	0.753517	0	353,114	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.700429	0	56,955	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.612574	0	191,796	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.575082	0	247	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.413203	0	162,219	0	0	69.00
69.01	06901	PULMONARY REHAB	0.824639	0	279,084	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.750307	0	114,180	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.655505	0	27,140	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.653206	0	528,130	18,534	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	2.122694	0	185,587	0	0	90.00
91.00	09100	EMERGENCY	1.080609	0	766,438	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.677382	0	136,638	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	3.716361	0	7,681	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	9,368,290	18,534	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	9,368,290	18,534	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	225,064	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	130,315	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	619,990	0	54.00
56.00	05600	RADIOISOTOPE	62,688	0	56.00
60.00	06000	LABORATORY	543,400	0	60.00
60.02	06002	GEO PSYCH	266,077	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	39,893	0	62.00
65.00	06500	RESPIRATORY THERAPY	117,489	0	65.00
66.00	06600	PHYSICAL THERAPY	142	0	66.00
69.00	06900	ELECTROCARDIOLOGY	67,029	0	69.00
69.01	06901	PULMONARY REHAB	230,144	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	85,670	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	17,790	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	344,978	12,107	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	393,944	0	90.00
91.00	09100	EMERGENCY	828,220	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92,556	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	93.00
93.01	04950	DIABETIC EDUCATION	28,545	0	93.01
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	4,093,934	12,107	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	4,093,934	12,107	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141305 | Component CCN: 14Z305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.511565	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.337295	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.411765	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.224688	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.290585	0	0	0	0	56.00
60.00	06000	LABORATORY	0.192178	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0.753517	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.700429	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0.612574	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.575082	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.413203	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0.824639	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.750307	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.655505	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.653206	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	2.122694	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.080609	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.677382	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	3.716361	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141305 | Component CCN: 14Z305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
60.02	06002	GEO PSYCH	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part I Date/Time Prepared: 11/25/2015 8:13 am

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	840,544	257,117	583,427	1,543	378.11	30.00
43.00	NURSERY	28,174		28,174	289	97.49	43.00
200.00	Total (lines 30-199)	868,718		611,601	1,832		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	289	109,274				30.00
43.00	NURSERY	165	16,086				43.00
200.00	Total (lines 30-199)	454	125,360				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/25/2015 8:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	311,746	2,414,385	0.129120	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	64,439	141,010	0.456982	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,410	1,622,813	0.002101	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	370,391	8,677,384	0.042685	0	0	54.00
56.00	05600	RADIOISOTOPE	25,201	458,640	0.054947	0	0	56.00
60.00	06000	LABORATORY	186,273	8,918,202	0.020887	0	0	60.00
60.02	06002	GEO PSYCH	26,252	435,011	0.060348	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	2,640	106,599	0.024766	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	64,313	755,692	0.085105	0	0	65.00
66.00	06600	PHYSICAL THERAPY	21,773	244,285	0.089130	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	79,590	427,959	0.185976	0	0	69.00
69.01	06901	PULMONARY REHAB	21,078	309,471	0.068110	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	48,981	1,048,161	0.046730	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,409	146,388	0.023287	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	125,630	1,844,635	0.068106	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	87,851	3,171,668	0.027699	0	0	88.00
90.00	09000	CLINIC	64,089	501,793	0.127720	0	0	90.00
91.00	09100	EMERGENCY	215,036	2,388,795	0.090019	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	142,723	613,844	0.232507	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	8,615	34,833	0.247323	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,873,440	34,261,568		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part III Date/Time Prepared: 11/25/2015 8:13 am

Title XIX | Hospital | PPS

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

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,543	0.00	289	0		30.00
43.00	04300	NURSERY	289	0.00	165	0		43.00
200.00		Total (lines 30-199)	1,832		454	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/25/2015 8:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	649,792	0	0	0	649,792	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.02	06002	GEO PSYCH	0	0	0	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY REHAB	0	0	0	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
93.01	04950	DIABETIC EDUCATION	0	0	0	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	649,792	0	0	0	649,792	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/25/2015 8:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,414,385	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	141,010	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,622,813	0.400411	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,677,384	0.000000	0.000000	0	54.00
56.00	05600	RADIOISOTOPE	0	458,640	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	8,918,202	0.000000	0.000000	0	60.00
60.02	06002	GEO PSYCH	0	435,011	0.000000	0.000000	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	106,599	0.000000	0.000000	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	755,692	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	244,285	0.000000	0.000000	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	427,959	0.000000	0.000000	0	69.00
69.01	06901	PULMONARY REHAB	0	309,471	0.000000	0.000000	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,048,161	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	146,388	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,844,635	0.000000	0.000000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,171,668	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	501,793	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	2,388,795	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	613,844	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0.000000	0.000000	0	93.00
93.01	04950	DIABETIC EDUCATION	0	34,833	0.000000	0.000000	0	93.01
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	34,261,568			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/25/2015 8:13 am

Title XIX | Hospital | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
60.02	06002	GEO PSYCH	0	0	0		60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	PULMONARY REHAB	0	0	0		69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
93.01	04950	DIABETIC EDUCATION	0	0	0		93.01
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141305	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/25/2015 8:13 am
	Title XVIII	Hospital	Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,269	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,543	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)	1,281	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	361	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)	319	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	18	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	28	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	638	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)	287	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	281	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	138.58	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,534,317	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	2,422	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	3,880	25.00
26.00	Total swing-bed cost (see instructions)	1,085,496	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,448,821	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,448,821	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,587.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,012,538	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,012,538	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	562,181	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,574,719	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	455,483	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	445,961	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	901,444	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)	262	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,587.05	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	415,807	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	840,544	2,448,821	0.343244	415,807	142,723	90.00
91.00	Nursing School cost	0	2,448,821	0.000000	415,807	0	91.00
92.00	Allied health cost	0	2,448,821	0.000000	415,807	0	92.00
93.00	All other Medical Education	0	2,448,821	0.000000	415,807	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141305	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/25/2015 8:13 am
	Title XIX	Hospital	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,269	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,543	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)	1,281	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)	680	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	19	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)	27	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	289	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)	289	15.00
16.00	Nursery days (title V or XIX only)	165	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,534,317	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	1,081,125	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,453,192	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,453,192	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,589.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	459,475	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)	459,475	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/25/2015 8:13 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	325,240	289	1,125.40	165	185,691	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	645,166	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)	125,360	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	125,360	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	519,806	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)	262	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,589.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	416,549	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/25/2015 8:13 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	840,544	2,453,192	0.342633	416,549	142,723	90.00
91.00	Nursing School cost	0	2,453,192	0.000000	416,549	0	91.00
92.00	Allied health cost	0	2,453,192	0.000000	416,549	0	92.00
93.00	All other Medical Education	0	2,453,192	0.000000	416,549	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		758,290		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.511565	105,462	53,951	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.337295	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.411765	57,040	23,487	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.224688	338,416	76,038	54.00
56.00	05600	RADIOISOTOPE	0.290585	7,670	2,229	56.00
60.00	06000	LABORATORY	0.192178	259,018	49,778	60.00
60.02	06002	GEO PSYCH	0.753517	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.700429	15,859	11,108	62.00
65.00	06500	RESPIRATORY THERAPY	0.612574	101,865	62,400	65.00
66.00	06600	PHYSICAL THERAPY	0.575082	33,248	19,120	66.00
69.00	06900	ELECTROCARDIOLOGY	0.413203	15,262	6,306	69.00
69.01	06901	PULMONARY REHAB	0.824639	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.750307	186,035	139,583	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.655505	24,568	16,104	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.653206	155,984	101,890	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.122694	0	0	90.00
91.00	09100	EMERGENCY	1.080609	173	187	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.677382	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	3.716361	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,300,600	562,181	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,300,600		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141305 | Component CCN: 14Z305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.511565	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.337295	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.411765	233	96	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.224688	27,713	6,227	54.00
56.00	05600	RADIOISOTOPE	0.290585	0	0	56.00
60.00	06000	LABORATORY	0.192178	81,961	15,751	60.00
60.02	06002	GEO PSYCH	0.753517	0	0	60.02
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0.700429	3,038	2,128	62.00
65.00	06500	RESPIRATORY THERAPY	0.612574	56,714	34,742	65.00
66.00	06600	PHYSICAL THERAPY	0.575082	154,697	88,963	66.00
69.00	06900	ELECTROCARDIOLOGY	0.413203	1,212	501	69.00
69.01	06901	PULMONARY REHAB	0.824639	0	0	69.01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.750307	59,741	44,824	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.655505	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.653206	59,577	38,916	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	2.122694	0	0	90.00
91.00	09100	EMERGENCY	1.080609	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.677382	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICE COST CENTER	0.000000	0	0	93.00
93.01	04950	DIABETIC EDUCATION	3.716361	0	0	93.01
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		444,886	232,148	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)		444,886		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141305	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/25/2015 8:13 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,106,041	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	4,106,041	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4,147,101	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	38,167	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,314,309	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)	2,794,625	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,794,625	30.00
31.00	Primary payer payments	1,928	31.00
32.00	Subtotal (line 30 minus line 31)	2,792,697	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)	228,861	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	173,934	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	217,910	36.00
37.00	Subtotal (see instructions)	2,966,631	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,966,631	40.00
40.01	Sequestration adjustment (see instructions)	59,333	40.01
41.00	Interim payments	2,904,755	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	2,543	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: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,511,478		2,963,159	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	06/15/2015	208,746		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	03/01/2015	73,656	03/01/2015	39,589	3.50
3.51			0	06/15/2015	18,815	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)		135,090		-58,404	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,646,568		2,904,755	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		2,543	6.01
6.02	SETTLEMENT TO PROGRAM		269,247		0	6.02
7.00	Total Medicare program liability (see instructions)		1,377,321		2,907,298	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: 141305 | Component CCN: 14Z305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/25/2015 8:13 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,118,357		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	06/15/2015	206,703		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	03/01/2015	26,110		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)		180,593		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,298,950		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		188,805		0	6.02
7.00	Total Medicare program liability (see instructions)		1,110,145		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: 141305	Period: From 07/01/2014 To 06/30/2015	Worksheet E-1 Part II Date/Time Prepared: 11/25/2015 8:13 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	507	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	638	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	106	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,281	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	36,573,812	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	426,235	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	235,620	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	185,574	8.00
9.00	Sequestration adjustment amount (see instructions)	3,711	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	181,863	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)	181,863	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141305 Component CCN: 14Z305	Period: From 07/01/2014 To 06/30/2015	Worksheet E-2 Date/Time Prepared: 11/25/2015 8:13 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	910,458	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	234,469	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	568	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,144,927	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,144,927	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,144,927	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	12,126	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,132,801	0	15.00
16.00		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,132,801	0	19.00
19.01	Sequestration adjustment (see instructions)	22,656	0	19.01
20.00	Interim payments	1,298,950	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-188,805	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141305	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part V Date/Time Prepared: 11/25/2015 8:13 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,574,719	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,574,719	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,590,466	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,590,466	19.00
20.00	Deductibles (exclude professional component)	213,800	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,376,666	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	1,376,666	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	37,847	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	28,764	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	37,847	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,405,430	28.00
29.00		0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,405,430	30.00
30.01	Sequestration adjustment (see instructions)	28,109	30.01
31.00	Interim payments	1,646,568	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	-269,247	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/25/2015 8:13 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4,462,326	0	0	0	1.00
2.00	Temporary investments	86,104	0	0	0	2.00
3.00	Notes receivable	33,398	0	0	0	3.00
4.00	Accounts receivable	3,933,564	0	0	0	4.00
5.00	Other receivable	152,855	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-667,000	0	0	0	6.00
7.00	Inventory	350,323	0	0	0	7.00
8.00	Prepaid expenses	159,875	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	8,511,445	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	504,757	0	0	0	12.00
13.00	Land improvements	1,238,964	0	0	0	13.00
14.00	Accumulated depreciation	-121,417	0	0	0	14.00
15.00	Buildings	24,835,015	0	0	0	15.00
16.00	Accumulated depreciation	-6,983,801	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	6,259,521	0	0	0	23.00
24.00	Accumulated depreciation	-4,220,353	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	1,985,603	0	0	0	27.00
28.00	Accumulated depreciation	-1,635,756	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)	21,862,533	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	8,672,157	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	1,190,070	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	9,862,227	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	40,236,205	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	1,875,305	0	0	0	37.00
38.00	Salaries, wages, and fees payable	606,945	0	0	0	38.00
39.00	Payroll taxes payable	71,950	0	0	0	39.00
40.00	Notes and loans payable (short term)	828,859	0	0	0	40.00
41.00	Deferred income	9,655	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	272,516	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,665,230	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	22,156,750	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	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	22,156,750	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	25,821,980	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	14,414,225				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)	14,414,225	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	40,236,205	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/25/2015 8:13 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		13,940,694		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		196,852				2.00
3.00	Total (sum of line 1 and line 2)		14,137,546		0		3.00
4.00	CONTRIBUTIONS AND GRANTS FOR LONG	275,390		0		0	4.00
5.00	RESTRICTED CONTRIBUTIONS	1,289		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)		276,679		0		10.00
11.00	Subtotal (line 3 plus line 10)		14,414,225		0		11.00
12.00		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)		14,414,225		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	CONTRIBUTIONS AND GRANTS FOR LONG		0			4.00
5.00	RESTRICTED CONTRIBUTIONS		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			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: 141305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/25/2015 8:13 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,505,090		2,505,090	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,505,090		2,505,090	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,505,090		2,505,090	17.00
18.00	Ancillary services	4,750,974	0	4,750,974	18.00
19.00	Outpatient services	0	32,415,811	32,415,811	19.00
20.00	RURAL HEALTH CLINIC	0	3,122,292	3,122,292	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHYSICIAN OFFICE	0	366,538	366,538	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	7,256,064	35,904,641	43,160,705	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,673,879		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00		0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		22,673,879		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141305	Period: From 07/01/2014 To 06/30/2015	Worksheet G-3 Date/Time Prepared: 11/25/2015 8:13 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	43,160,705	1.00
2.00	Less contractual allowances and discounts on patients' accounts	20,983,879	2.00
3.00	Net patient revenues (line 1 minus line 2)	22,176,826	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	22,673,879	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-497,053	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	3,060	6.00
7.00	Income from investments	-43,276	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	7,505	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	33,765	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	4,407	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	53,671	22.00
23.00	Governmental appropriations	84,468	23.00
24.00	HOSPITAL OTHER INCOME	20,648	24.00
24.01	EQUITY EARNINGS ON INVESTMENTS	258,218	24.01
24.02	NURSING HOME OTHER INCOME	0	24.02
24.03	NET ASSETS RELEASED FROM RESTRICTION	0	24.03
24.04		0	24.04
24.05	SALARY REIMBURSEMENTS	39,116	24.05
24.06	EHR INCENTIVE	237,189	24.06
25.00	Total other income (sum of lines 6-24)	698,771	25.00
26.00	Total (line 5 plus line 25)	201,718	26.00
27.00	LOSS ON DISPOSAL	4,866	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	4,866	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	196,852	29.00

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

Provider CCN: 141305 Component CCN: 143456 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/25/2015 8:13 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	397,568	0	397,568	-57,812	339,756	1.00
2.00	Physician Assistant	391,366	0	391,366	-9,888	381,478	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	277,533	0	277,533	0	277,533	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,066,467	0	1,066,467	-67,700	998,767	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	90,422	90,422	0	90,422	12.00
13.00	Other Costs Under Agreement	0	22,742	22,742	0	22,742	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	113,164	113,164	0	113,164	14.00
15.00	Medical Supplies	0	172,107	172,107	0	172,107	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	10,060	10,060	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	67,933	67,933	0	67,933	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	240,040	240,040	10,060	250,100	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,066,467	353,204	1,419,671	-57,640	1,362,031	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	0	0	0	0	29.00
30.00	Administrative Costs	0	149,750	149,750	9,841	159,591	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	149,750	149,750	9,841	159,591	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,066,467	502,954	1,569,421	-47,799	1,521,622	32.00

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

Provider CCN: 141305 Component CCN: 143456 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/25/2015 8:13 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	339,756		1.00
2.00	Physician Assistant	0	381,478		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	277,533		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	998,767		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	90,422		12.00
13.00	Other Costs Under Agreement	0	22,742		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	113,164		14.00
15.00	Medical Supplies	0	172,107		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	10,060		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	67,933		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	250,100		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,362,031		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-8,607	150,984		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-8,607	150,984		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-8,607	1,513,015		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141305 Component CCN: 143456

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

Worksheet M-2

Date/Time Prepared: 11/25/2015 8:13 am

Rural Health Clinic (RHC) I

Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.86	2,785	4,200	3,612		1.00
2.00	Physician Assistant	1.91	5,532	2,100	4,011		2.00
3.00	Nurse Practitioner	1.43	5,173	2,100	3,003		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.20	13,490		10,626	13,490	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	0.16	166			166	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)	4.36	13,656			13,656	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)					1,362,031	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)					1,362,031	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)					150,984	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					730,529	15.00
16.00	Total overhead (sum of lines 14 and 15)					881,513	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					881,513	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					881,513	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,243,544	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141305 Component CCN: 143456	Period: From 07/01/2014 To 06/30/2015	Worksheet M-3 Date/Time Prepared: 11/25/2015 8:13 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		2,243,544	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		34,742	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,208,802	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		13,656	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)		13,656	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		161.75	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)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	161.75	161.75	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,609	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	260,256	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) *		260,256	16.00
16.01	Total program charges (see instructions)(from contractor's records)		317,429	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		41,889	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		34,344	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.)		162,764	16.04
16.05	Total program cost (see instructions)		197,108	16.05
17.00	Primary payer amounts		31	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		22,457	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		50,617	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		197,077	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		16,714	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		213,791	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			0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		213,791	26.00
26.01	Sequestration adjustment (see instructions)		4,276	26.01
27.00	Interim payments		162,282	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)		47,233	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: 141305 Component CCN: 143456	Period: From 07/01/2014 To 06/30/2015	Worksheet M-4 Date/Time Prepared: 11/25/2015 8:13 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	998,767	998,767	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000814	0.001775	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	813	1,773	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	15,201	3,305	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	16,014	5,078	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,362,031	1,362,031	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	881,513	881,513	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.011757	0.003728	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	10,364	3,286	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	26,378	8,364	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	100	218	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	263.78	38.37	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	51	85	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	13,453	3,261	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)		34,742	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)		16,714	16.00

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

Provider CCN: 141305 Component CCN: 143456

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

Worksheet M-5

Date/Time Prepared: 11/25/2015 8:13 am

Rural Health Clinic (RHC) I

Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		159,443	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		03/01/2015	2,839	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)		2,839	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		162,282	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		47,233	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		209,515	7.00

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