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: 141308	Period: From 05/01/2014 To 04/30/2015	Worksheet S Parts I-III Date/Time Prepared: 9/24/2015 2:26 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 9/24/2015 Time: 2:26 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WASHINGTON COUNTY HOSPITAL (141308) for the cost reporting period beginning 05/01/2014 and ending 04/30/2015 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	5,240	-50,819	1,871	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	5,785	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-15,552		0	10.00
200.00	Total	0	11,025	-66,371	1,871	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: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 9/24/2015 1:35 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 705 SOUTH GRAND AVENUE	PO Box:			1.00
2.00	City: NASHVILLE	State: IL	Zip Code: 62263	County: WASHINGTON	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	WASHINGTON COUNTY HOSPITAL	141308	99914	1	12/01/2000	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	WASHINGTON COUNTY SWING BED	14Z308	99914		08/18/2000	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	WASHINTON COUNTY EXTENDED CARE								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	GRAND STREET RHC	143472	99914		08/01/2005	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	05/01/2014	04/30/2015	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	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: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/24/2015 1:35 pm

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/24/2015 1:35 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 9/24/2015 1:35 pm

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			0	76.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 9/24/2015 1:35 pm

		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/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N	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.	N	N	N	N	109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	11,730	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141308	Period: From 05/01/2014 To 04/30/2015	Worksheet S-2 Part I Date/Time Prepared: 9/24/2015 1:35 pm

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

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

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

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	Y		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	Y		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 Section §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	65,171	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141308	Period: From 05/01/2014 To 04/30/2015	Worksheet S-2 Part I Date/Time Prepared: 9/24/2015 1:35 pm

		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
			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: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 9/24/2015 1:35 pm

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	07/31/2015	Y
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
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 9/24/2015 1:35 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					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.			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.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			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.	ELAINE	MATZENBACHER	41.00
42.00	Enter the employer/company name of the cost report preparer.	WASHINGTON COUNTY HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	618-327-2207	EMATZENBACHER@WASHINGTONCOUNTYHOSPIT	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 9/24/2015 1:35 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	07/31/2015			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.		CFO		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: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 9/24/2015 1:35 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	22	8,030	6,919.00	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)		22	8,030	6,919.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		22	8,030	6,919.00	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	28	10,220			21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	115.00					23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		50				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: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 9/24/2015 1:35 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	215	30	284			1.00
2.00	HMO and other (see instructions)	0	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	1,775	0	1,833			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	183			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,990	30	2,300			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,990	30	2,300	0.00	105.40	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			9,694	0.00	17.69	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)				0.00	0.00	23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2,138	0	6,959	0.00	11.99	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	135.08	27.00
28.00	Observation Bed Days		0	29			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 9/24/2015 1:35 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	67	8	93	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	67	8	93	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				15	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)	0.00					23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141308 Component CCN: 143472 | Period: From 05/01/2014 To 04/30/2015 | Worksheet S-8 Date/Time Prepared: 9/24/2015 1:35 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	705 SOUTH GRAND AVE	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	NASHVILLE	IL	62263	2.00

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:30	19:00	07:30	11.00

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

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

		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	N	0	0	0	0	15.00

			County				
			4.00				
2.00	City, State, Zip Code, County		WASHINGTON				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	19:00	07:30	19:00	07:30	19:00	11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141308 Component CCN: 143472	Period: From 05/01/2014 To 04/30/2015	Worksheet S-8 Date/Time Prepared: 9/24/2015 1:35 pm
		Rural Health Clinic (RHC) I	Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:30	19:00	08:00	14:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141308	Period: From 05/01/2014 To 04/30/2015	Worksheet S-10 Date/Time Prepared: 9/24/2015 1:35 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.584000	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,349,597	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	2,602,326	6.00
7.00	Medicaid cost (line 1 times line 6)	1,519,758	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)	170,161	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	170,161	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	100,587	25,872	126,459	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	58,743	15,109	73,852	21.00
22.00	Partial payment by patients approved for charity care	2,790	1,700	4,490	22.00
23.00	Cost of charity care (line 21 minus line 22)	55,953	13,409	69,362	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)	512,293	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	74,512	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	437,781	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	255,664	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	325,026	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	495,187	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A | Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		273,840	273,840	69,689	343,529	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		389,099	389,099	0	389,099	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	76,656	2,002,921	2,079,577	0	2,079,577	4.00
5.01	00550	INFORMATION SYSTEMS	245,006	313,588	558,594	-49,515	509,079	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	789,931	573,525	1,363,456	41,327	1,404,783	5.02
6.00	00600	MAINTENANCE & REPAIRS	123,696	408,002	531,698	0	531,698	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	82,940	82,940	0	82,940	8.00
9.00	00900	HOUSEKEEPING	202,099	23,176	225,275	0	225,275	9.00
10.00	01000	DIETARY	230,687	136,592	367,279	-28,244	339,035	10.00
11.00	01100	CAFETERIA	0	0	0	28,244	28,244	11.00
13.00	01300	NURSING ADMINISTRATION	85,741	608	86,349	0	86,349	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	50,521	8,707	59,228	0	59,228	14.00
15.00	01500	PHARMACY	118,052	20,332	138,384	0	138,384	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	158,195	41,660	199,855	0	199,855	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	4,628	4,628	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	216,699	0	216,699	13,800	230,499	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	627,035	39,469	666,504	-4,628	661,876	30.00
46.00	04600	OTHER LONG TERM CARE	550,564	23,928	574,492	0	574,492	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	202,867	121,906	324,773	0	324,773	50.00
53.00	05300	ANESTHESIOLOGY	0	28,329	28,329	-13,800	14,529	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	307,488	288,603	596,091	49,515	645,606	54.00
60.00	06000	LABORATORY	370,759	579,238	949,997	0	949,997	60.00
65.00	06500	RESPIRATORY THERAPY	37,874	58,057	95,931	0	95,931	65.00
66.00	06600	PHYSICAL THERAPY	766,312	43,219	809,531	0	809,531	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	48,570	6,199	54,769	0	54,769	68.01
69.00	06900	ELECTROCARDIOLOGY	5,341	12,272	17,613	0	17,613	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	81,745	81,745	-15,198	66,547	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,198	15,198	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	610,678	610,678	0	610,678	73.00
76.00	03480	ONCOLOGY	6,493	940	7,433	0	7,433	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,153,585	232,055	1,385,640	-41,327	1,344,313	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	349,411	1,188,370	1,537,781	0	1,537,781	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		72,304	72,304	-72,304	0	113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,723,582	7,662,302	14,385,884	-2,615	14,383,269	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,658	3,658	2,615	6,273	190.00
190.01	19001	OUTPATIENT CLINIC	4,292	565	4,857	0	4,857	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	6,727,874	7,666,525	14,394,399	0	14,394,399	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A | Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	343,529		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-193,104	195,995		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-26,009	2,053,568		4.00
5.01	00550	INFORMATION SYSTEMS	0	509,079		5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	-44,042	1,360,741		5.02
6.00	00600	MAINTENANCE & REPAIRS	0	531,698		6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	82,940		8.00
9.00	00900	HOUSEKEEPING	0	225,275		9.00
10.00	01000	DIETARY	0	339,035		10.00
11.00	01100	CAFETERIA	-8,520	19,724		11.00
13.00	01300	NURSING ADMINISTRATION	0	86,349		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2,282	56,946		14.00
15.00	01500	PHARMACY	0	138,384		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-795	199,060		16.00
17.00	01700	SOCIAL SERVICE	0	4,628		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	230,499		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	661,876		30.00
46.00	04600	OTHER LONG TERM CARE	0	574,492		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	324,773		50.00
53.00	05300	ANESTHESIOLOGY	0	14,529		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-5,024	640,582		54.00
60.00	06000	LABORATORY	-5,074	944,923		60.00
65.00	06500	RESPIRATORY THERAPY	0	95,931		65.00
66.00	06600	PHYSICAL THERAPY	0	809,531		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	0	54,769		68.01
69.00	06900	ELECTROCARDIOLOGY	-12,156	5,457		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	66,547		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,198		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-4,840	605,838		73.00
76.00	03480	ONCOLOGY	0	7,433		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-122,689	1,221,624		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-195,420	1,342,361		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-619,955	13,763,314		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,273		190.00
190.01	19001	OUTPATIENT CLINIC	0	4,857		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0		190.02
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-619,955	13,774,444		200.00

RECLASSIFICATIONS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-6 | Date/Time Prepared: 9/24/2015 1:35 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - RECLASSIFY CAFETERIA COSTS					
1.00	CAFETERIA	11.00	17,740	10,504		1.00
	TOTALS		17,740	10,504		
	B - RECLASS SOCIAL SERVICE COST					
1.00	SOCIAL SERVICE	17.00	4,628	0		1.00
	TOTALS		4,628	0		
	C - RECLASS PROFESSIONAL LIABILITY INSUR					
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	46,387		1.00
	TOTALS		0	46,387		
	D - RECLASSIFY XRAY DIRECTORS SALARY					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	49,515	0		1.00
	TOTALS		49,515	0		
	E - RECLASSIFY ANESTHESIA PRO FEES					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	13,800		1.00
	TOTALS		0	13,800		
	F - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	72,304		1.00
	TOTALS		0	72,304		
	G - TO RECLASS INTEROCULAR LENS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	15,198		1.00
	TOTALS		0	15,198		
	H - TO RECLASS ANNEX BLDG DEPRECIATION					
1.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00	0	2,615		1.00
	TOTALS		0	2,615		
	I - RECLASS SALARIES FOR A-8 RHC OFFSET					
1.00	RURAL HEALTH CLINIC	88.00	0	114,244		1.00
	TOTALS		0	114,244		
	J - TO RCLS PHYS RECRUIT EXP FOR CLINIC					
1.00	RURAL HEALTH CLINIC	88.00	0	5,060		1.00
	TOTALS		0	5,060		
500.00	Grand Total: Increases		71,883	280,112		500.00

RECLASSIFICATIONS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-6 | Date/Time Prepared: 9/24/2015 1:35 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RECLASSIFY CAFETERIA COSTS						
1.00	DIETARY	10.00	17,740	10,504	0		1.00
	TOTALS		17,740	10,504			
	B - RECLASS SOCIAL SERVICE COST						
1.00	ADULTS & PEDIATRICS	30.00	4,628	0	0		1.00
	TOTALS		4,628	0			
	C - RECLASS PROFESSIONAL LIABILITY INSUR						
1.00	RURAL HEALTH CLINIC	88.00	0	46,387	0		1.00
	TOTALS		0	46,387			
	D - RECLASSIFY XRAY DIRECTORS SALARY						
1.00	INFORMATION SYSTEMS	5.01	49,515	0	0		1.00
	TOTALS		49,515	0			
	E - RECLASSIFY ANESTHESIA PRO FEES						
1.00	ANESTHESIOLOGY	53.00	0	13,800	0		1.00
	TOTALS		0	13,800			
	F - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	72,304	9		1.00
	TOTALS		0	72,304			
	G - TO RECLASS INTEROCULAR LENS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	15,198	0		1.00
	TOTALS		0	15,198			
	H - TO RECLASS ANNEX BLDG DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,615	9		1.00
	TOTALS		0	2,615			
	I - RECLASS SALARIES FOR A-8 RHC OFFSET						
1.00	RURAL HEALTH CLINIC	88.00	114,244	0	0		1.00
	TOTALS		114,244	0			
	J - TO RCLS PHYS RECRUIT EXP FOR CLINIC						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	5,060	0		1.00
	TOTALS		0	5,060			
500.00	Grand Total: Decreases		186,127	165,868			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 9/24/2015 1:35 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	62,855	0	0	0	0	1.00
2.00	Land Improvements	372,841	28,806	0	28,806	0	2.00
3.00	Buildings and Fixtures	9,397,166	38,672	0	38,672	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	6,513,118	90,978	0	90,978	1,195,333	6.00
7.00	HIT designated Assets	861,870	65,171	0	65,171	0	7.00
8.00	Subtotal (sum of lines 1-7)	17,207,850	223,627	0	223,627	1,195,333	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	17,207,850	223,627	0	223,627	1,195,333	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	62,855	0	1.00
2.00	Land Improvements	401,647	0	2.00
3.00	Buildings and Fixtures	9,435,838	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	5,408,763	0	6.00
7.00	HIT designated Assets	927,041	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,236,144	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	16,236,144	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 9/24/2015 1:35 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	273,840	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	389,099	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	662,939	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	273,840		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	389,099		2.00
3.00	Total (sum of lines 1-2)	0	662,939		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 9/24/2015 1:35 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	9,900,340	0	9,900,340	0.609772	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	6,335,804	0	6,335,804	0.390228	0	2.00
3.00	Total (sum of lines 1-2)	16,236,144	0	16,236,144	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	343,529	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	195,995	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	539,524	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	343,529	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	195,995	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	539,524	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8 | Date/Time Prepared: 9/24/2015 1:35 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)	B	-19,494	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-2,282	CENTRAL SERVICES & SUPPLY	14.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-212,600			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-133	OTHER ADMINISTRATIVE AND GENERAL	5.02	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	-8,520	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	-795	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		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	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	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-192,557	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	MISCELLANEOUS REVENUE - FLU SHOTS	B	-4,840	DRUGS CHARGED TO PATIENTS	73.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8 | Date/Time Prepared: 9/24/2015 1:35 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	MISCELLANEOUS REVENUE - OTHER	B	-3,596	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.01
34.00	LAB FEES	A	-5,074	LABORATORY	60.00	0	34.00
35.00	EDUCATION FEES	B	-75	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	35.00
36.00	NONALLOWABLE PUBLIC RELATIONS	A	-26,046	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	36.00
37.00	HEALTHLINK ADMIN FEES	A	29,042	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	37.00
38.00	LOBBYING PORTION OF DUES	A	-16,144	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	38.00
39.00	NON-RHC SERVICES	A	-122,689	RURAL HEALTH CLINIC	88.00	0	39.00
40.00	NON-RHC BENEFITS	A	-26,009	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41.00	TELEPHONE SERVICE	B	-7,596	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	41.00
42.00	NON-RHC DEPRECIATION	A	-547	CAP REL COSTS-MVBLE EQUIP	2.00	9	42.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-619,955				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: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 9/24/2015 1:35 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	54.00	RADIOLOGY-DIAGNOSTIC	5,024	5,024	0	0	0	1.00
2.00	60.00	LABORATORY	21,270	0	21,270	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	12,156	12,156	0	0	0	3.00
4.00	91.00	EMERGENCY	1,165,991	195,420	970,571	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,204,441	212,600	991,841		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	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	1.00
2.00	60.00	LABORATORY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	5,024		1.00
2.00	60.00	LABORATORY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	12,156		3.00
4.00	91.00	EMERGENCY	0	0	0	195,420		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	212,600		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	INFORMATION SYSTEMS	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	343,529	343,529				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	195,995		195,995			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,053,568	627	0	2,054,195		4.00
5.01	00550	INFORMATION SYSTEMS	509,079	4,571	0	61,431	575,081	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	1,360,741	72,868	0	248,229	113,275	5.02
6.00	00600	MAINTENANCE & REPAIRS	531,698	54,609	2,741	38,870	8,713	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	82,940	4,305	0	0	0	8.00
9.00	00900	HOUSEKEEPING	225,275	1,972	0	63,508	8,713	9.00
10.00	01000	DIETARY	339,035	8,078	564	66,917	13,070	10.00
11.00	01100	CAFETERIA	19,724	3,968	0	5,575	0	11.00
13.00	01300	NURSING ADMINISTRATION	86,349	627	0	26,943	8,713	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	56,946	3,611	6,925	15,876	8,713	14.00
15.00	01500	PHARMACY	138,384	4,419	2,847	37,097	17,427	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	199,060	4,628	74	49,712	26,140	16.00
17.00	01700	SOCIAL SERVICE	4,628	418	0	1,454	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	230,499	0	0	68,096	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	661,876	30,479	9,249	195,586	52,280	30.00
46.00	04600	OTHER LONG TERM CARE	574,492	43,390	841	173,010	17,427	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	324,773	16,057	46,573	63,749	21,783	50.00
53.00	05300	ANESTHESIOLOGY	14,529	0	2,376	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	640,582	21,269	102,276	112,185	47,923	54.00
60.00	06000	LABORATORY	944,923	9,589	1,425	116,508	21,783	60.00
65.00	06500	RESPIRATORY THERAPY	95,931	2,262	2,863	11,902	0	65.00
66.00	06600	PHYSICAL THERAPY	809,531	9,375	5,360	240,807	69,707	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	54,769	2,001	1,156	15,263	4,357	68.01
69.00	06900	ELECTROCARDIOLOGY	5,457	276	1,430	1,678	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,547	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,198	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	605,838	0	0	0	0	73.00
76.00	03480	ONCOLOGY	7,433	1,126	51	2,040	4,357	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,221,624	11,457	121	326,610	82,777	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,342,361	16,375	7,048	109,800	26,140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,763,314	328,357	193,920	2,052,846	553,298	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,273	1,159	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	4,857	14,013	2,075	1,349	21,783	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	13,774,444	343,529	195,995	2,054,195	575,081	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I | Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5A.01	5.02	6.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	1,795,113	1,795,113				5.02
6.00	00600	MAINTENANCE & REPAIRS	636,631	95,400	732,031			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,245	13,074	14,946	115,265		8.00
9.00	00900	HOUSEKEEPING	299,468	44,876	6,846	0	351,190	9.00
10.00	01000	DIETARY	427,664	64,086	28,045	0	13,867	10.00
11.00	01100	CAFETERIA	29,267	4,386	13,775	0	6,811	11.00
13.00	01300	NURSING ADMINISTRATION	122,632	18,377	2,178	0	1,077	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	92,071	13,797	12,538	0	6,200	14.00
15.00	01500	PHARMACY	200,174	29,996	15,342	0	7,586	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	279,614	41,900	16,068	0	7,945	16.00
17.00	01700	SOCIAL SERVICE	6,500	974	1,452	0	718	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	298,595	44,745	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	949,470	142,279	105,813	13,377	52,321	30.00
46.00	04600	OTHER LONG TERM CARE	809,160	121,253	150,638	77,206	74,487	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	472,935	70,870	55,744	3,506	27,564	50.00
53.00	05300	ANESTHESIOLOGY	16,905	2,533	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	924,235	138,498	73,842	3,944	36,512	54.00
60.00	06000	LABORATORY	1,094,228	163,971	33,291	0	16,462	60.00
65.00	06500	RESPIRATORY THERAPY	112,958	16,927	7,853	291	3,883	65.00
66.00	06600	PHYSICAL THERAPY	1,134,780	170,048	32,549	10,393	16,094	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	77,546	11,620	6,945	0	3,434	68.01
69.00	06900	ELECTROCARDIOLOGY	8,841	1,325	957	0	473	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,547	9,972	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,198	2,277	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	605,838	90,785	0	0	0	73.00
76.00	03480	ONCOLOGY	15,007	2,249	3,910	0	1,933	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,642,589	246,141	39,775	250	19,667	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,501,724	225,035	56,849	6,011	28,110	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,722,935	1,787,394	679,356	114,978	325,144	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,432	1,114	4,025	0	1,990	190.00
190.01	19001	OUTPATIENT CLINIC	44,077	6,605	48,650	287	24,056	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	13,774,444	1,795,113	732,031	115,265	351,190	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	533,662					10.00
11.00	01100	CAFETERIA	0	54,239				11.00
13.00	01300	NURSING ADMINISTRATION	0	605	144,869			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	872	0	125,478		14.00
15.00	01500	PHARMACY	0	630	0	170	253,898	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,518	0	437	0	16.00
17.00	01700	SOCIAL SERVICE	0	605	0	0	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	110,566	7,531	52,162	21,648	83	30.00
46.00	04600	OTHER LONG TERM CARE	420,232	10,708	0	13,397	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,161	14,387	7,193	5	50.00
53.00	05300	ANESTHESIOLOGY	0	605	0	2,275	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	3,747	0	31,479	230	54.00
60.00	06000	LABORATORY	0	4,613	0	2,989	51	60.00
65.00	06500	RESPIRATORY THERAPY	0	636	4,162	800	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7,355	0	1,835	565	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	0	305	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	708	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	14,018	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,454	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	252,810	73.00
76.00	03480	ONCOLOGY	0	79	0	566	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,258	49,895	1,532	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	3,547	24,263	12,380	154	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	530,798	54,178	144,869	125,478	253,898	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	61	0	0	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	2,864	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	533,662	54,239	144,869	125,478	253,898	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	348,482					16.00
17.00	01700	SOCIAL SERVICE	0	10,249				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	343,340			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,541	9,224		1,482,015	-32,534	30.00
46.00	04600	OTHER LONG TERM CARE	18,043	1,025		1,696,149	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,246	0	0	682,611	0	50.00
53.00	05300	ANESTHESIOLOGY	2,145	0	343,340	367,803	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	89,265	0	0	1,301,752	0	54.00
60.00	06000	LABORATORY	67,059	0	0	1,382,664	0	60.00
65.00	06500	RESPIRATORY THERAPY	5,994	0	0	153,504	0	65.00
66.00	06600	PHYSICAL THERAPY	40,477	0	0	1,414,096	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	1,389	0	0	101,239	0	68.01
69.00	06900	ELECTROCARDIOLOGY	3,715	0	0	16,019	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,452	0	0	91,989	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	568	0	0	32,497	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,507	0	0	984,940	0	73.00
76.00	03480	ONCOLOGY	1,201	0	0	24,945	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,229	0	0	2,019,336	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	23,651	0	0	1,881,724	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	32,534	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	348,482	10,249	343,340	13,633,283	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	14,561	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	0	0	123,736	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	2,864	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments			0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	348,482	10,249	343,340	13,774,444	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part I | Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	INFORMATION SYSTEMS			5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL			5.02
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	1,449,481		30.00
46.00	04600	OTHER LONG TERM CARE	1,696,149		46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	682,611		50.00
53.00	05300	ANESTHESIOLOGY	367,803		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,301,752		54.00
60.00	06000	LABORATORY	1,382,664		60.00
65.00	06500	RESPIRATORY THERAPY	153,504		65.00
66.00	06600	PHYSICAL THERAPY	1,414,096		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
68.01	06801	CARDIAC REHAB	101,239		68.01
69.00	06900	ELECTROCARDIOLOGY	16,019		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,989		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,497		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	984,940		73.00
76.00	03480	ONCOLOGY	24,945		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	2,019,336		88.00
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	1,881,724		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	32,534		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		98.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,633,283		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,561		190.00
190.01	19001	OUTPATIENT CLINIC	123,736		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	2,864		190.02
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	13,774,444		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	627	0	627	627	4.00
5.01	00550	INFORMATION SYSTEMS	0	4,571	0	4,571	19	5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	0	72,868	0	72,868	76	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	54,609	2,741	57,350	12	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	4,305	0	4,305	0	8.00
9.00	00900	HOUSEKEEPING	0	1,972	0	1,972	19	9.00
10.00	01000	DIETARY	0	8,078	564	8,642	20	10.00
11.00	01100	CAFETERIA	0	3,968	0	3,968	2	11.00
13.00	01300	NURSING ADMINISTRATION	0	627	0	627	8	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,611	6,925	10,536	5	14.00
15.00	01500	PHARMACY	0	4,419	2,847	7,266	11	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,628	74	4,702	15	16.00
17.00	01700	SOCIAL SERVICE	0	418	0	418	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	21	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	30,479	9,249	39,728	60	30.00
46.00	04600	OTHER LONG TERM CARE	0	43,390	841	44,231	53	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	16,057	46,573	62,630	19	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,376	2,376	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	21,269	102,276	123,545	34	54.00
60.00	06000	LABORATORY	0	9,589	1,425	11,014	36	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,262	2,863	5,125	4	65.00
66.00	06600	PHYSICAL THERAPY	0	9,375	5,360	14,735	74	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	2,001	1,156	3,157	5	68.01
69.00	06900	ELECTROCARDIOLOGY	0	276	1,430	1,706	1	69.00
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
76.00	03480	ONCOLOGY	0	1,126	51	1,177	1	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	11,457	121	11,578	98	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	16,375	7,048	23,423	34	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	328,357	193,920	522,277	627	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,159	0	1,159	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	14,013	2,075	16,088	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	343,529	195,995	539,524	627	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	INFORMATION SYSTEMS	OTHER ADMINISTRATIVE AND GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	6.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS	4,590					5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	902	73,846				5.02
6.00	00600	MAINTENANCE & REPAIRS	70	3,924	61,356			6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	538	1,253	6,096		8.00
9.00	00900	HOUSEKEEPING	70	1,846	574	0	4,481	9.00
10.00	01000	DIETARY	104	2,636	2,351	0	177	10.00
11.00	01100	CAFETERIA	0	180	1,155	0	87	11.00
13.00	01300	NURSING ADMINISTRATION	70	756	183	0	14	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	70	568	1,051	0	79	14.00
15.00	01500	PHARMACY	139	1,234	1,286	0	97	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	209	1,724	1,347	0	101	16.00
17.00	01700	SOCIAL SERVICE	0	40	122	0	9	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	1,841	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	417	5,853	8,869	707	668	30.00
46.00	04600	OTHER LONG TERM CARE	139	4,988	12,624	4,084	949	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	174	2,915	4,672	185	352	50.00
53.00	05300	ANESTHESIOLOGY	0	104	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	382	5,697	6,189	209	466	54.00
60.00	06000	LABORATORY	174	6,745	2,790	0	210	60.00
65.00	06500	RESPIRATORY THERAPY	0	696	658	15	50	65.00
66.00	06600	PHYSICAL THERAPY	556	6,995	2,728	550	205	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	35	478	582	0	44	68.01
69.00	06900	ELECTROCARDIOLOGY	0	54	80	0	6	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	410	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	94	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,734	0	0	0	73.00
76.00	03480	ONCOLOGY	35	93	328	0	25	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	661	10,128	3,334	13	251	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	209	9,257	4,765	318	359	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,416	73,528	56,941	6,081	4,149	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	46	337	0	25	190.00
190.01	19001	OUTPATIENT CLINIC	174	272	4,078	15	307	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,590	73,846	61,356	6,096	4,481	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
			10.00	11.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	13,930					10.00
11.00	01100	CAFETERIA	0	5,392				11.00
13.00	01300	NURSING ADMINISTRATION	0	60	1,718			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	87	0	12,396		14.00
15.00	01500	PHARMACY	0	63	0	17	10,113	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	250	0	43	0	16.00
17.00	01700	SOCIAL SERVICE	0	60	0	0	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	2,886	749	618	2,139	3	30.00
46.00	04600	OTHER LONG TERM CARE	10,969	1,063	0	1,324	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	215	171	711	0	50.00
53.00	05300	ANESTHESIOLOGY	0	60	0	225	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	373	0	3,109	9	54.00
60.00	06000	LABORATORY	0	459	0	295	2	60.00
65.00	06500	RESPIRATORY THERAPY	0	63	49	79	0	65.00
66.00	06600	PHYSICAL THERAPY	0	731	0	181	23	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	0	30	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	70	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1,385	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,428	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	10,070	73.00
76.00	03480	ONCOLOGY	0	8	0	56	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	722	592	151	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	353	288	1,223	6	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,855	5,386	1,718	12,396	10,113	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	6	0	0	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	75	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	13,930	5,392	1,718	12,396	10,113	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			16.00	17.00	19.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,391					16.00
17.00	01700	SOCIAL SERVICE	0	649				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	1,862			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	422	584		63,703	0	30.00
46.00	04600	OTHER LONG TERM CARE	434	65		80,923	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	679	0		72,723	0	50.00
53.00	05300	ANESTHESIOLOGY	52	0		2,817	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,157	0		142,170	0	54.00
60.00	06000	LABORATORY	1,613	0		23,338	0	60.00
65.00	06500	RESPIRATORY THERAPY	144	0		6,883	0	65.00
66.00	06600	PHYSICAL THERAPY	973	0		27,751	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0		0	0	68.00
68.01	06801	CARDIAC REHAB	33	0		4,364	0	68.01
69.00	06900	ELECTROCARDIOLOGY	89	0		2,006	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	35	0		1,830	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14	0		1,536	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	854	0		14,658	0	73.00
76.00	03480	ONCOLOGY	29	0		1,752	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	294	0		27,822	0	88.00
90.00	09000	CLINIC	0	0		0	0	90.00
91.00	09100	EMERGENCY	569	0		40,804	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0		0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,391	649	0	515,080	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		1,567	0	190.00
190.01	19001	OUTPATIENT CLINIC	0	0		20,940	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0		75	0	190.02
191.00	19100	RESEARCH	0	0		0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		0	0	192.00
193.00	19300	NONPAID WORKERS	0	0		0	0	193.00
200.00		Cross Foot Adjustments			1,862	1,862	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,391	649	1,862	539,524	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B Part II | Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00550	INFORMATION SYSTEMS			5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL			5.02
6.00	00600	MAINTENANCE & REPAIRS			6.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	63,703		30.00
46.00	04600	OTHER LONG TERM CARE	80,923		46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	72,723		50.00
53.00	05300	ANESTHESIOLOGY	2,817		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	142,170		54.00
60.00	06000	LABORATORY	23,338		60.00
65.00	06500	RESPIRATORY THERAPY	6,883		65.00
66.00	06600	PHYSICAL THERAPY	27,751		66.00
67.00	06700	OCCUPATIONAL THERAPY	0		67.00
68.00	06800	SPEECH PATHOLOGY	0		68.00
68.01	06801	CARDIAC REHAB	4,364		68.01
69.00	06900	ELECTROCARDIOLOGY	2,006		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,830		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,536		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,658		73.00
76.00	03480	ONCOLOGY	1,752		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	27,822		88.00
90.00	09000	CLINIC	0		90.00
91.00	09100	EMERGENCY	40,804		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		98.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	515,080		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,567		190.00
190.01	19001	OUTPATIENT CLINIC	20,940		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	75		190.02
191.00	19100	RESEARCH	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
193.00	19300	NONPAID WORKERS	0		193.00
200.00		Cross Foot Adjustments	1,862		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	539,524		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	INFORMATION SYSTEMS (# OF COMPUTERS)	Reconciliation	
			1.00	2.00	4.00	5.01	5A.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	72,293					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		205,853				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	132	0	6,536,974			4.00
5.01	00550	INFORMATION SYSTEMS	962	0	195,491	132		5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	15,334	0	789,931	26	-1,795,113	5.02
6.00	00600	MAINTENANCE & REPAIRS	11,492	2,879	123,696	2	0	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	906	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	415	0	202,099	2	0	9.00
10.00	01000	DIETARY	1,700	592	212,947	3	0	10.00
11.00	01100	CAFETERIA	835	0	17,740	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	132	0	85,741	2	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	760	7,273	50,521	2	0	14.00
15.00	01500	PHARMACY	930	2,990	118,052	4	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	974	78	158,195	6	0	16.00
17.00	01700	SOCIAL SERVICE	88	0	4,628	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	216,699	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,414	9,714	622,407	12	0	30.00
46.00	04600	OTHER LONG TERM CARE	9,131	883	550,564	4	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,379	48,916	202,867	5	0	50.00
53.00	05300	ANESTHESIOLOGY	0	2,495	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,476	107,421	357,003	11	0	54.00
60.00	06000	LABORATORY	2,018	1,497	370,759	5	0	60.00
65.00	06500	RESPIRATORY THERAPY	476	3,007	37,874	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,973	5,630	766,312	16	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	421	1,214	48,570	1	0	68.01
69.00	06900	ELECTROCARDIOLOGY	58	1,502	5,341	0	0	69.00
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
76.00	03480	ONCOLOGY	237	54	6,493	1	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,411	127	1,039,341	19	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,446	7,402	349,411	6	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	69,100	203,674	6,532,682	127	-1,795,113	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	244	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	2,949	2,179	4,292	5	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	343,529	195,995	2,054,195	575,081		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.751899	0.952111	0.314242	4,356.674242		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			627	4,590		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000096	34.772727		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			5.02	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL	11,979,331					5.02
6.00	00600	MAINTENANCE & REPAIRS	636,631	44,373				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	87,245	906	31,331			8.00
9.00	00900	HOUSEKEEPING	299,468	415	0	43,052		9.00
10.00	01000	DIETARY	427,664	1,700	0	1,700	40,616	10.00
11.00	01100	CAFETERIA	29,267	835	0	835	0	11.00
13.00	01300	NURSING ADMINISTRATION	122,632	132	0	132	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	92,071	760	0	760	0	14.00
15.00	01500	PHARMACY	200,174	930	0	930	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	279,614	974	0	974	0	16.00
17.00	01700	SOCIAL SERVICE	6,500	88	0	88	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	298,595	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	949,470	6,414	3,636	6,414	8,415	30.00
46.00	04600	OTHER LONG TERM CARE	809,160	9,131	20,986	9,131	31,983	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	472,935	3,379	953	3,379	0	50.00
53.00	05300	ANESTHESIOLOGY	16,905	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	924,235	4,476	1,072	4,476	0	54.00
60.00	06000	LABORATORY	1,094,228	2,018	0	2,018	0	60.00
65.00	06500	RESPIRATORY THERAPY	112,958	476	79	476	0	65.00
66.00	06600	PHYSICAL THERAPY	1,134,780	1,973	2,825	1,973	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	77,546	421	0	421	0	68.01
69.00	06900	ELECTROCARDIOLOGY	8,841	58	0	58	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,547	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,198	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	605,838	0	0	0	0	73.00
76.00	03480	ONCOLOGY	15,007	237	0	237	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,642,589	2,411	68	2,411	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,501,724	3,446	1,634	3,446	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,927,822	41,180	31,253	39,859	40,398	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,432	244	0	244	0	190.00
190.01	19001	OUTPATIENT CLINIC	44,077	2,949	78	2,949	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	218	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,795,113	732,031	115,265	351,190	533,662	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.149851	16.497217	3.678944	8.157345	13.139206	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	73,846	61,356	6,096	4,481	13,930	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.006164	1.382733	0.194568	0.104083	0.342968	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00550	INFORMATION SYSTEMS						5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL						5.02
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	8,960					11.00
13.00	01300	NURSING ADMINISTRATION	100	66,167				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	144	0	131,940			14.00
15.00	01500	PHARMACY	104	0	179	613,307		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	416	0	459	0	23,344,675	16.00
17.00	01700	SOCIAL SERVICE	100	0	0	0	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	1,244	23,824	22,763	201	1,175,058	30.00
46.00	04600	OTHER LONG TERM CARE	1,769	0	14,087	0	1,208,648	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	357	6,571	7,563	13	1,892,143	50.00
53.00	05300	ANESTHESIOLOGY	100	0	2,392	0	143,686	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	619	0	33,101	555	5,980,020	54.00
60.00	06000	LABORATORY	762	0	3,143	124	4,492,194	60.00
65.00	06500	RESPIRATORY THERAPY	105	1,901	841	0	401,553	65.00
66.00	06600	PHYSICAL THERAPY	1,215	0	1,929	1,365	2,711,513	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	321	0	93,080	68.01
69.00	06900	ELECTROCARDIOLOGY	117	0	0	0	248,855	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	14,740	0	97,292	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	15,198	0	38,046	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	610,678	2,378,568	73.00
76.00	03480	ONCOLOGY	13	0	595	0	80,459	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,199	22,789	1,611	0	819,211	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	586	11,082	13,018	371	1,584,349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,950	66,167	131,940	613,307	23,344,675	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	OUTPATIENT CLINIC	10	0	0	0	0	190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0	0	0	0	190.02
191.00	19100	RESEARCH	0	0	0	0	0	191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	54,239	144,869	125,478	253,898	348,482	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	6.053460	2.189445	0.951023	0.413982	0.014928	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,392	1,718	12,396	10,113	8,391	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.601786	0.025965	0.093952	0.016489	0.000359	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-1 | Date/Time Prepared: 9/24/2015 1:35 pm

		Cost Center Description	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			17.00	19.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00550	INFORMATION SYSTEMS				5.01
5.02	00591	OTHER ADMINISTRATIVE AND GENERAL				5.02
6.00	00600	MAINTENANCE & REPAIRS				6.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE	100			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	90			30.00
46.00	04600	OTHER LONG TERM CARE	10			46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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
76.00	03480	ONCOLOGY	0	0		76.00
		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)				92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	0		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	100	100		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
190.01	19001	OUTPATIENT CLINIC	0	0		190.01
190.02	19003	NON-REIMBURSEABLE OUTPATIENT MEALS	0	0		190.02
191.00	19100	RESEARCH	0	0		191.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	10,249	343,340		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	102.490000	3,433.400000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	649	1,862		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.490000	18.620000		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet B-2 | Date/Time Prepared: 9/24/2015 1:35 pm

		Description	Worksheet Part	Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		ADULTS AND PEDIATRICS	1	30.00	-32,534	7.00
8.00		OTHER OUTPATIENT SERVICES	1	93.00	32,534	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,449,481		1,449,481	0	0	30.00
46.00	04600	OTHER LONG TERM CARE	1,696,149		1,696,149	0	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	682,611		682,611	0	0	50.00
53.00	05300	ANESTHESIOLOGY	367,803		367,803	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,301,752		1,301,752	0	0	54.00
60.00	06000	LABORATORY	1,382,664		1,382,664	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	153,504	0	153,504	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,414,096	0	1,414,096	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	101,239	0	101,239	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	16,019		16,019	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,989		91,989	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,497		32,497	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	984,940		984,940	0	0	73.00
76.00	03480	ONCOLOGY	24,945		24,945	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,019,336		2,019,336	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	1,881,724		1,881,724	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	19,255		19,255		0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	32,534		32,534	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
200.00		Subtotal (see instructions)	13,652,538	0	13,652,538	0	0	200.00
201.00		Less Observation Beds	19,255		19,255		0	201.00
202.00		Total (see instructions)	13,633,283	0	13,633,283	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges: Inpatient	Charges: Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	778,107		778,107			30.00
46.00	04600	OTHER LONG TERM CARE	1,208,648		1,208,648			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,475	1,888,668	1,892,143	0.360761	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,580	142,106	143,686	2.559769	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	107,915	5,872,105	5,980,020	0.217684	0.000000	54.00
60.00	06000	LABORATORY	212,741	4,279,453	4,492,194	0.307793	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	204,552	197,001	401,553	0.382276	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	573,830	2,137,683	2,711,513	0.521515	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	93,080	93,080	1.087656	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	4,152	244,703	248,855	0.064371	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,637	83,655	97,292	0.945494	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	38,046	38,046	0.854150	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	579,279	1,799,289	2,378,568	0.414089	0.000000	73.00
76.00	03480	ONCOLOGY	0	80,459	80,459	0.310034	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	819,211	819,211			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	512	1,583,837	1,584,349	1.187695	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	22,240	22,240	0.865782	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	14,995	359,716	374,711	0.086824	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
200.00		Subtotal (see instructions)	3,703,423	19,641,252	23,344,675			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,703,423	19,641,252	23,344,675			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	CARDIAC REHAB	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
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
76.00	03480	ONCOLOGY	0.000000		76.00
		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	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
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: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/24/2015 1:35 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,449,481		1,449,481	0	1,449,481	30.00
46.00	04600	OTHER LONG TERM CARE	1,696,149		1,696,149	0	1,696,149	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	682,611		682,611	0	682,611	50.00
53.00	05300	ANESTHESIOLOGY	367,803		367,803	0	367,803	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,301,752		1,301,752	0	1,301,752	54.00
60.00	06000	LABORATORY	1,382,664		1,382,664	0	1,382,664	60.00
65.00	06500	RESPIRATORY THERAPY	153,504	0	153,504	0	153,504	65.00
66.00	06600	PHYSICAL THERAPY	1,414,096	0	1,414,096	0	1,414,096	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	101,239	0	101,239	0	101,239	68.01
69.00	06900	ELECTROCARDIOLOGY	16,019		16,019	0	16,019	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	91,989		91,989	0	91,989	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,497		32,497	0	32,497	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	984,940		984,940	0	984,940	73.00
76.00	03480	ONCOLOGY	24,945		24,945	0	24,945	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,019,336		2,019,336	0	2,019,336	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	1,881,724		1,881,724	0	1,881,724	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	19,255		19,255		19,255	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	32,534		32,534	0	32,534	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0		0		0	115.00
200.00		Subtotal (see instructions)	13,652,538	0	13,652,538	0	13,652,538	200.00
201.00		Less Observation Beds	19,255		19,255		19,255	201.00
202.00		Total (see instructions)	13,633,283	0	13,633,283	0	13,633,283	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/24/2015 1:35 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	778,107		778,107			30.00
46.00	04600	OTHER LONG TERM CARE	1,208,648		1,208,648			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,475	1,888,668	1,892,143	0.360761	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,580	142,106	143,686	2.559769	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	107,915	5,872,105	5,980,020	0.217684	0.000000	54.00
60.00	06000	LABORATORY	212,741	4,279,453	4,492,194	0.307793	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	204,552	197,001	401,553	0.382276	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	573,830	2,137,683	2,711,513	0.521515	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
68.01	06801	CARDIAC REHAB	0	93,080	93,080	1.087656	0.000000	68.01
69.00	06900	ELECTROCARDIOLOGY	4,152	244,703	248,855	0.064371	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13,637	83,655	97,292	0.945494	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	38,046	38,046	0.854150	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	579,279	1,799,289	2,378,568	0.414089	0.000000	73.00
76.00	03480	ONCOLOGY	0	80,459	80,459	0.310034	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	819,211	819,211	2.464977	0.000000	88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	512	1,583,837	1,584,349	1.187695	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	22,240	22,240	0.865782	0.000000	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	14,995	359,716	374,711	0.086824	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	0.000000	98.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)	0	0	0			115.00
200.00		Subtotal (see instructions)	3,703,423	19,641,252	23,344,675			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	3,703,423	19,641,252	23,344,675			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet C Part I Date/Time Prepared: 9/24/2015 1:35 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
68.01	06801	CARDIAC REHAB	0.000000		68.01
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
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
76.00	03480	ONCOLOGY	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		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	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000		98.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
115.00	11500	AMBULATORY SURGICAL CENTER (D.P.)			115.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part II Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	72,723	1,892,143	0.038434	1,764	68	50.00
53.00	05300	ANESTHESIOLOGY	2,817	143,686	0.019605	950	19	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	142,170	5,980,020	0.023774	44,573	1,060	54.00
60.00	06000	LABORATORY	23,338	4,492,194	0.005195	62,849	327	60.00
65.00	06500	RESPIRATORY THERAPY	6,883	401,553	0.017141	46,902	804	65.00
66.00	06600	PHYSICAL THERAPY	27,751	2,711,513	0.010235	16,383	168	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
68.01	06801	CARDIAC REHAB	4,364	93,080	0.046884	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	2,006	248,855	0.008061	2,595	21	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,830	97,292	0.018809	2,703	51	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,536	38,046	0.040372	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,658	2,378,568	0.006163	74,052	456	73.00
76.00	03480	ONCOLOGY	1,752	80,459	0.021775	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	27,822	819,211	0.033962	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	40,804	1,584,349	0.025754	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,902	22,240	0.265378	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	374,711	0.000000	5,497	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00		Total (lines 50-199)	376,356	21,357,920		258,268	2,974	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	343,340	0	0	0	343,340	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	0	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
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
76.00	03480	ONCOLOGY	0	0	0	0	0	76.00
		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	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	343,340	0	0	0	343,340	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,892,143	0.000000	0.000000	1,764	50.00
53.00	05300	ANESTHESIOLOGY	0	143,686	2.389516	0.000000	950	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,980,020	0.000000	0.000000	44,573	54.00
60.00	06000	LABORATORY	0	4,492,194	0.000000	0.000000	62,849	60.00
65.00	06500	RESPIRATORY THERAPY	0	401,553	0.000000	0.000000	46,902	65.00
66.00	06600	PHYSICAL THERAPY	0	2,711,513	0.000000	0.000000	16,383	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
68.01	06801	CARDIAC REHAB	0	93,080	0.000000	0.000000	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0	248,855	0.000000	0.000000	2,595	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	97,292	0.000000	0.000000	2,703	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	38,046	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,378,568	0.000000	0.000000	74,052	73.00
76.00	03480	ONCOLOGY	0	80,459	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	819,211	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	1,584,349	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	22,240	0.000000	0.000000	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	374,711	0.000000	0.000000	5,497	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00		Total (lines 50-199)	0	21,357,920			258,268	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part IV | Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	2,270	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
68.01	06801	CARDIAC REHAB	0	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
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
76.00	03480	ONCOLOGY	0	0	0		76.00
		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	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
200.00		Total (lines 50-199)	2,270	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part V Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.360761	0	793,021	0	0	50.00
53.00	05300	ANESTHESIOLOGY	2.559769	0	58,721	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217684	0	2,183,144	0	0	54.00
60.00	06000	LABORATORY	0.307793	0	1,799,431	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.382276	0	52,862	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.521515	0	736,806	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	1.087656	0	47,915	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.064371	0	110,652	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.945494	0	28,249	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.854150	0	29,094	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414089	0	1,100,245	1,639	0	73.00
76.00	03480	ONCOLOGY	0.310034	0	52,565	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.187695	0	456,107	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.865782	0	16,175	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.086824	0	186,690	2,277	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		0	7,651,677	3,916	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	7,651,677	3,916	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part V Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	286,091	0		50.00
53.00	05300	ANESTHESIOLOGY	150,312	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	475,236	0		54.00
60.00	06000	LABORATORY	553,852	0		60.00
65.00	06500	RESPIRATORY THERAPY	20,208	0		65.00
66.00	06600	PHYSICAL THERAPY	384,255	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	52,115	0		68.01
69.00	06900	ELECTROCARDIOLOGY	7,123	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	26,709	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,851	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	455,599	679		73.00
76.00	03480	ONCOLOGY	16,297	0		76.00
		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	541,716	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	14,004	0		92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	16,209	198		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	3,024,577	877		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,024,577	877		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141308 | Component CCN: 14Z308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part V Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.360761	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	2.559769	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217684	0	0	0	0	54.00
60.00	06000	LABORATORY	0.307793	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.382276	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.521515	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
68.01	06801	CARDIAC REHAB	1.087656	0	0	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.064371	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.945494	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.854150	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414089	0	0	0	0	73.00
76.00	03480	ONCOLOGY	0.310034	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	1.187695	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.865782	0	0	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.086824	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
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: 141308 | Component CCN: 14Z308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D Part V | Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
68.01	06801	CARDIAC REHAB	0	0		68.01
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
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
76.00	03480	ONCOLOGY	0	0		76.00
		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	04950	OTHER OUTPATIENT SERVICE COST CENTER	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,329	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	313	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)	284	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,273	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)	560	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	114	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)	69	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	215	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)	1,227	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)	548	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,449,481	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)	15,338	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)	9,283	25.00
26.00	Total swing-bed cost (see instructions)	1,241,660	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	207,821	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)	207,821	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)	663.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	142,751	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)	142,751	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	92,453	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	235,204	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)	814,679	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	363,850	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,178,529	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	29	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	663.96	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	19,255	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-1 | Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	63,703	207,821	0.306528	19,255	5,902	90.00
91.00	Nursing School cost	0	207,821	0.000000	19,255	0	91.00
92.00	Allied health cost	0	207,821	0.000000	19,255	0	92.00
93.00	All other Medical Education	0	207,821	0.000000	19,255	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-3 | Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		162,055		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.360761	1,764	636	50.00
53.00	05300	ANESTHESIOLOGY	2.559769	950	2,432	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217684	44,573	9,703	54.00
60.00	06000	LABORATORY	0.307793	62,849	19,344	60.00
65.00	06500	RESPIRATORY THERAPY	0.382276	46,902	17,930	65.00
66.00	06600	PHYSICAL THERAPY	0.521515	16,383	8,544	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801	CARDIAC REHAB	1.087656	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.064371	2,595	167	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.945494	2,703	2,556	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.854150	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414089	74,052	30,664	73.00
76.00	03480	ONCOLOGY	0.310034	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1.187695	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.865782	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.086824	5,497	477	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		258,268	92,453	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)		258,268		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141308 | Component CCN: 14Z308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet D-3 | Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.360761	1,487	536	50.00
53.00	05300	ANESTHESIOLOGY	2.559769	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.217684	49,487	10,773	54.00
60.00	06000	LABORATORY	0.307793	106,021	32,633	60.00
65.00	06500	RESPIRATORY THERAPY	0.382276	126,557	48,380	65.00
66.00	06600	PHYSICAL THERAPY	0.521515	506,849	264,329	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
68.01	06801	CARDIAC REHAB	1.087656	0	0	68.01
69.00	06900	ELECTROCARDIOLOGY	0.064371	692	45	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.945494	7,808	7,382	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.854150	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.414089	395,769	163,884	73.00
76.00	03480	ONCOLOGY	0.310034	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	1.187695	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.865782	0	0	92.00
93.00	04950	OTHER OUTPATIENT SERVICE COST CENTER	0.086824	6,707	582	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		1,201,377	528,544	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)		1,201,377		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E Part B Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Hospital | Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,025,454	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,025,454	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	3,055,709	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)	15,447	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,174,499	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	1,865,763	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	1,865,763	30.00
31.00	Primary payer payments	2,045	31.00
32.00	Subtotal (line 30 minus line 31)	1,863,718	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)	85,480	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	64,965	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	85,480	36.00
37.00	Subtotal (see instructions)	1,928,683	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,928,683	40.00
40.01	Sequestration adjustment (see instructions)	38,574	40.01
41.00	Interim payments	1,940,928	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-50,819	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: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		187,881		2,083,420	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	01/01/2015	7,632	04/30/2015	95,258	3.01
3.02			0	01/01/2015	18,442	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	04/30/2015	18,160	04/30/2015	256,192	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)		-10,528		-142,492	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)		177,353		1,940,928	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		5,240		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		50,819	6.02
7.00	Total Medicare program liability (see instructions)		182,593		1,890,109	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: 141308 | Component CCN: 14Z308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 9/24/2015 1:35 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,710,864		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	01/01/2015	29,289		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	04/30/2015	134,603		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)		-105,314		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)		1,605,550		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		5,785		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,611,335		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: 141308	Period: From 05/01/2014 To 04/30/2015	Worksheet E-1 Part II Date/Time Prepared: 9/24/2015 1:35 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	93	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	215	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	284	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	23,344,675	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	126,459	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	65,171	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	62,642	8.00
9.00	Sequestration adjustment amount (see instructions)	1,253	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	61,389	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	59,518	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	1,871	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141308 Component CCN: 14Z308	Period: From 05/01/2014 To 04/30/2015	Worksheet E-2 Date/Time Prepared: 9/24/2015 1:35 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,190,314	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	533,829	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	1,775	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)	1,724,143	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,724,143	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)	1,724,143	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	79,924	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)	1,644,219	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,644,219	0	19.00
19.01	Sequestration adjustment (see instructions)	32,884	0	19.01
20.00	Interim payments	1,605,550	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)	5,785	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141308	Period: From 05/01/2014 To 04/30/2015	Worksheet E-3 Part V Date/Time Prepared: 9/24/2015 1:35 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	235,204	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)	235,204	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	237,556	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)	237,556	19.00
20.00	Deductibles (exclude professional component)	54,970	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	182,586	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	182,586	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	4,912	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	3,733	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	186,319	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	186,319	30.00
30.01	Sequestration adjustment (see instructions)	3,726	30.01
31.00	Interim payments	177,353	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)	5,240	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: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G | Date/Time Prepared: 9/24/2015 1:35 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	1,494,833	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	2,365,314	0	0	0	4.00
5.00	Other receivable	43,574	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-522,000	0	0	0	6.00
7.00	Inventory	324,424	0	0	0	7.00
8.00	Prepaid expenses	94,897	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)	3,801,042	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	62,855	0	0	0	12.00
13.00	Land improvements	401,647	0	0	0	13.00
14.00	Accumulated depreciation	-367,269	0	0	0	14.00
15.00	Buildings	9,435,837	0	0	0	15.00
16.00	Accumulated depreciation	-7,055,205	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	5,408,763	0	0	0	23.00
24.00	Accumulated depreciation	-4,566,040	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	927,041	0	0	0	27.00
28.00	Accumulated depreciation	-772,296	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)	3,475,333	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,301,666	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	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,301,666	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	8,578,041	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	264,352	0	0	0	37.00
38.00	Salaries, wages, and fees payable	621,144	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	264,367	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	789,581	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,939,444	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	1,633,332	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	1,633,332	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	3,572,776	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	5,005,265				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)	5,005,265	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	8,578,041	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G-1 | Date/Time Prepared: 9/24/2015 1:35 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		5,032,315		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-27,050				2.00
3.00	Total (sum of line 1 and line 2)		5,005,265		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		5,005,265		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		5,005,265		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet G-2 Parts I & II | Date/Time Prepared: 9/24/2015 1:35 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	248,487		248,487	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	529,620		529,620	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	1,208,648		1,208,648	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,986,755		1,986,755	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)	1,986,755		1,986,755	17.00
18.00	Ancillary services	1,701,673	19,551,427	21,253,100	18.00
19.00	Outpatient services	0	374,711	374,711	19.00
20.00	RURAL HEALTH CLINIC	0	1,314,753	1,314,753	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.)	0	0	0	25.00
26.00	HOSPICE				26.00
27.00	CHARITY CARE	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	3,688,428	21,240,891	24,929,319	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		14,394,399		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		14,394,399		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141308	Period: From 05/01/2014 To 04/30/2015	Worksheet G-3 Date/Time Prepared: 9/24/2015 1:35 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	24,929,319	1.00
2.00	Less contractual allowances and discounts on patients' accounts	11,180,038	2.00
3.00	Net patient revenues (line 1 minus line 2)	13,749,281	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	14,394,399	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-645,118	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	20,402	6.00
7.00	Income from investments	23,646	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	2,511	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	14,939	22.00
23.00	Governmental appropriations	360,671	23.00
24.00	GRANT INCOME	70,943	24.00
24.01	MEDICARE AND MEDICAID INCENTIVE REV	88,673	24.01
24.02	GAIN ON DISPOSAL OF FIXED ASSETS	699	24.02
24.03	OTHER MISCELLANEOUS INCOME	35,584	24.03
25.00	Total other income (sum of lines 6-24)	618,068	25.00
26.00	Total (line 5 plus line 25)	-27,050	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-27,050	29.00

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

Provider CCN: 141308 Component CCN: 143472 | Period: From 05/01/2014 To 04/30/2015 | Worksheet M-1 | Date/Time Prepared: 9/24/2015 1:35 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	742,569	0	742,569	0	742,569	1.00
2.00	Physician Assistant	83,200	0	83,200	0	83,200	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	327,816	0	327,816	0	327,816	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	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,153,585	0	1,153,585	0	1,153,585	10.00
11.00	Physician Services Under Agreement	0	147,660	147,660	0	147,660	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	14,995	14,995	0	14,995	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	162,655	162,655	0	162,655	14.00
15.00	Medical Supplies	0	6,394	6,394	0	6,394	15.00
16.00	Transportation (Health Care Staff)	0	2,290	2,290	0	2,290	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	46,387	46,387	-46,387	0	18.00
19.00	Other Health Care Costs	0	0	0	5,060	5,060	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	55,071	55,071	-41,327	13,744	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,153,585	217,726	1,371,311	-41,327	1,329,984	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	6,859	6,859	0	6,859	29.00
30.00	Administrative Costs	0	7,470	7,470	0	7,470	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	14,329	14,329	0	14,329	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,153,585	232,055	1,385,640	-41,327	1,344,313	32.00

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

Provider CCN: 141308 | Component CCN: 143472 | Period: From 05/01/2014 To 04/30/2015 | Worksheet M-1 | Date/Time Prepared: 9/24/2015 1:35 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	-114,244	628,325		1.00
2.00	Physician Assistant	0	83,200		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	327,816		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	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	-114,244	1,039,341		10.00
11.00	Physician Services Under Agreement	-6,900	140,760		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	14,995		13.00
14.00	Subtotal (sum of lines 11 through 13)	-6,900	155,755		14.00
15.00	Medical Supplies	-6	6,388		15.00
16.00	Transportation (Health Care Staff)	-219	2,071		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	5,060		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	-225	13,519		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-121,369	1,208,615		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	-1,320	5,539		29.00
30.00	Administrative Costs	0	7,470		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-1,320	13,009		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-122,689	1,221,624		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141308 | Period: From 05/01/2014 To 04/30/2015 | Worksheet M-2

Component CCN: 143472 | Date/Time Prepared: 9/24/2015 1:35 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.32	5,227	4,200	9,744		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.72	1,732	2,100	1,512		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.04	6,959		11,256	11,256	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3.04	6,959			11,256	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)					1,208,615	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)					1,208,615	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)					13,009	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					797,712	15.00
16.00	Total overhead (sum of lines 14 and 15)					810,721	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					810,721	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					810,721	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,019,336	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141308 Component CCN: 143472	Period: From 05/01/2014 To 04/30/2015	Worksheet M-3 Date/Time Prepared: 9/24/2015 1:35 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		2,019,336	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		20,518	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,998,818	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		11,256	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)		11,256	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		177.58	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)	177.58	177.58	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,138	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	379,666	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) *		379,666	16.00
16.01	Total program charges (see instructions)(from contractor's records)		257,898	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		280,557	16.04
16.05	Total program cost (see instructions)		280,557	16.05
17.00	Primary payer amounts		123	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		28,970	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		45,786	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		280,434	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,881	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		284,315	22.00
23.00	Allowable bad debts (see instructions)		7,650	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		5,814	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		7,650	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		290,129	26.00
26.01	Sequestration adjustment (see instructions)		5,803	26.01
27.00	Interim payments		299,878	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)		-15,552	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: 141308 | Component CCN: 143472 | Period: From 05/01/2014 To 04/30/2015 | Worksheet M-4 | Date/Time Prepared: 9/24/2015 1:35 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,039,341	1,039,341	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001522	0.004140	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	1,582	4,303	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	3,862	2,534	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	5,444	6,837	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,208,615	1,208,615	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	810,721	810,721	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.004504	0.005657	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	3,651	4,586	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	9,095	11,423	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	57	155	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	159.56	73.70	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	10	31	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,596	2,285	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)		20,518	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)		3,881	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141308 Component CCN: 143472	Period: From 05/01/2014 To 04/30/2015	Worksheet M-5 Date/Time Prepared: 9/24/2015 1:35 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		275,672	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		01/01/2015	25,610	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		04/30/2015	1,404	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)		24,206	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		299,878	4.00
	TO BE COMPLETED BY CONTRACTOR			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
	Program to Provider			
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
	Provider to Program			
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		15,552	6.02
7.00	Total Medicare program liability (see instructions)		284,326	7.00

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