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).

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

PART I - COST REPORT STATUS

Provider [ ] Electronically filed cost report

[ ] Manually submitted cost report

[ ] If this is an amended report enter the number of times the provider resubmitted this cost report

[ ] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor [ ] As Submitted

[ ] Settled without Audit

[ ] Settled with Audit

[ ] Reopened

[ ] Amended

Date/Time Prepared: 9/24/2015 2:26 pm

Worksheet S Parts I-III

Date/Time Prepared: 9/24/2015 2:26 pm

PART II - CERTIFICATION

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

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>$1.00</th>
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<th>$3.00</th>
<th>$4.00</th>
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<td></td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<tr>
<td>Rural Health Clinic</td>
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<td>-66,371</td>
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</tr>
<tr>
<td>Total</td>
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<td>11,025</td>
<td>-66,371</td>
<td>1,871</td>
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</tbody>
</table>

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: OMB, 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

<table>
<thead>
<tr>
<th>Component Name</th>
<th>CCN Number</th>
<th>CBSA Code</th>
<th>Provider Type</th>
<th>Date Certified</th>
<th>Payment System (P, T, O, or N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
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<tr>
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### Hospital and Hospital-Based Component Identification

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<td>08/01/2005</td>
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<tr>
<td>Renal Dialysis</td>
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### Inpatient PPS Information

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<th>Period (mm/dd/yyyy)</th>
<th>Type of Control (see instructions)</th>
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### In-State Medicaid Paid Days

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<tr>
<th>Period (mm/dd/yyyy)</th>
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<th>Out-of-State Medicaid Eligible Unpaid Days</th>
<th>Other Medicaid Eligible Unpaid Days</th>
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<tbody>
<tr>
<td>01/01/2014 - 06/30/2014</td>
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<tr>
<td>07/01/2014 - 12/31/2014</td>
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### Out-of-State Medicaid Eligible Unpaid Days

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<th>Period (mm/dd/yyyy)</th>
<th>Out-of-State Medicaid Eligible Unpaid Days</th>
<th>Other Medicaid Eligible Unpaid Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2014 - 06/30/2014</td>
<td>5.00</td>
<td></td>
</tr>
<tr>
<td>07/01/2014 - 12/31/2014</td>
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### Other Medicaid Eligible Unpaid Days

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<th>Period (mm/dd/yyyy)</th>
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</tr>
</thead>
<tbody>
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<td>01/01/2014 - 06/30/2014</td>
<td></td>
</tr>
<tr>
<td>07/01/2014 - 12/31/2014</td>
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### HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

<table>
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<th>Provider CCN: 141308</th>
<th>Period: 03/01/2014 To 04/30/2015</th>
<th>Worksheet S-2 Part I</th>
<th>Date/Time Prepared: 09/24/2015 1:35 pm</th>
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</table>

<table>
<thead>
<tr>
<th>Urban/Rural S</th>
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<th>N</th>
<th>N</th>
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</thead>
<tbody>
<tr>
<td>1.00</td>
<td>2.00</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>26.00</th>
<th>Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter &quot;1&quot; for urban or &quot;2&quot; for rural.</th>
<th>2</th>
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</thead>
<tbody>
<tr>
<td>27.00</td>
<td>Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, &quot;1&quot; for urban or &quot;2&quot; for rural. If applicable, enter the effective date of the geographic reclassification in column 2.</td>
<td>2</td>
</tr>
<tr>
<td>35.00</td>
<td>If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.</td>
<td>0</td>
</tr>
</tbody>
</table>

| 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 |

<table>
<thead>
<tr>
<th>37.00</th>
<th>If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.</th>
<th>37.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>38.00</td>
<td>Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.</td>
<td>38.00</td>
</tr>
</tbody>
</table>

| 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 |

| 40.00 | 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 |

### Prospective Payment System (PPS) - Capital

| 45.00 | Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR §412.320? (see instructions) | N |

| 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 |

| 47.00 | Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no. | N |

| 48.00 | Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. | N |

### 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 |

| 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 Wkst. D, Parts III and IV and D-2, Pt. II, if applicable. | N |

| 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5. | N |

| 59.00 | Are costs claimed on line 100 of Worksheet A2? If yes, complete Wkst. D-2, Pt. I. | N |

### Provider OPERATIONS DATA

| 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 |

| 61.00 | Did your hospital receive FTE slots under ACA §5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) | N |

| 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 |

| 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 |

| 61.03 | Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) | 0.00 |

| 61.04 | Enter the number of unweighted primary care/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions) | 0.00 |

| 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 |

| 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 |
### HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Program Code</th>
<th>Unweighted IME FTE Count</th>
<th>Unweighted Direct GME FTE Count</th>
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</thead>
<tbody>
<tr>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 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. 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.

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Program Code</th>
<th>Unweighted IME FTE Count</th>
<th>Unweighted Direct GME FTE Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 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. 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.

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Program Code</th>
<th>Unweighted IME FTE Count</th>
<th>Unweighted Direct GME FTE Count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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. Enter in column 1, the program name, 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 FTE residents that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)).

<table>
<thead>
<tr>
<th>Unweighted FTEs Nonprovider Site</th>
<th>Unweighted FTEs in Hospital</th>
<th>Ratio (col. 3/ (col. 3 + col. 4))</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td>0.00</td>
<td>0.000000</td>
</tr>
</tbody>
</table>

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.

### 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 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 FTE residents that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)).

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Program Code</th>
<th>Unweighted FTEs Nonprovider Site</th>
<th>Unweighted FTEs in Hospital</th>
<th>Ratio (col. 3/ (col. 3 + col. 4))</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>0.00</td>
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</table>

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 FTE residents that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)).
<table>
<thead>
<tr>
<th>Program Name</th>
<th>Program Code</th>
<th>Unweighted FTEs</th>
<th>Unweighted FTEs in Hospital</th>
<th>Ratio (col. 1/ (col. 1 + col. 2))</th>
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<th>Program Name</th>
<th>Program Code</th>
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<th>Unweighted FTEs in Hospital</th>
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<tr>
<th>Program Name</th>
<th>Program Code</th>
<th>Unweighted FTEs</th>
<th>Unweighted FTEs in Hospital</th>
<th>Ratio (col. 1/ (col. 1 + col. 2))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long Term Care Hospital PPS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>0</td>
<td></td>
<td></td>
<td>81.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Program Code</th>
<th>Unweighted FTEs</th>
<th>Unweighted FTEs in Hospital</th>
<th>Ratio (col. 3/ (col. 3 + col. 4))</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEFRA Providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>0</td>
<td></td>
<td></td>
<td>86.00</td>
</tr>
</tbody>
</table>
### Title V and XIX Services

<table>
<thead>
<tr>
<th>Line</th>
<th>Question</th>
<th>Column 1</th>
<th>Column 2</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>90.00</td>
<td>Does this facility have title V and/or XIX inpatient hospital services? Enter &quot;Y&quot; for yes or &quot;N&quot; for no in the applicable column.</td>
<td>N</td>
<td>Y</td>
<td>90.00</td>
</tr>
<tr>
<td>91.00</td>
<td>Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter &quot;Y&quot; for yes or &quot;N&quot; for no in the applicable column.</td>
<td>N</td>
<td>N</td>
<td>91.00</td>
</tr>
<tr>
<td>92.00</td>
<td>Are title XVII NF patients occupying title XVII SNF beds (dual certification?) (see instructions) Enter &quot;Y&quot; for yes or &quot;N&quot; for no in the applicable column.</td>
<td>N</td>
<td>N</td>
<td>92.00</td>
</tr>
<tr>
<td>93.00</td>
<td>Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter &quot;Y&quot; for yes or &quot;N&quot; for no in the applicable column.</td>
<td>N</td>
<td>N</td>
<td>93.00</td>
</tr>
<tr>
<td>94.00</td>
<td>Does title V or XIX reduce capital cost? Enter &quot;Y&quot; for yes, and &quot;N&quot; for no in the applicable column.</td>
<td>N</td>
<td>N</td>
<td>94.00</td>
</tr>
<tr>
<td>95.00</td>
<td>Does title V or XIX reduce operating cost? Enter &quot;Y&quot; for yes or &quot;N&quot; for no in the applicable column.</td>
<td>N</td>
<td>N</td>
<td>95.00</td>
</tr>
<tr>
<td>96.00</td>
<td>If line 96 is &quot;Y&quot;, enter the reduction percentage in the applicable column.</td>
<td>0.00</td>
<td>0.00</td>
<td>96.00</td>
</tr>
<tr>
<td>97.00</td>
<td>If line 97 is &quot;Y&quot;, enter the reduction percentage in the applicable column.</td>
<td>0.00</td>
<td>0.00</td>
<td>97.00</td>
</tr>
</tbody>
</table>

### Miscellaneous Cost Reporting Information

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>2.00</td>
<td>3.00</td>
<td>4.00</td>
</tr>
</tbody>
</table>

### Rural Providers

<table>
<thead>
<tr>
<th>Physical</th>
<th>Occupational</th>
<th>Speech</th>
<th>Respiratory</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>1.00</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Title V and XIX Services

<table>
<thead>
<tr>
<th>Line</th>
<th>Question</th>
<th>Column 1</th>
<th>Column 2</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>105.00</td>
<td>Does this hospital qualify as a Critical Access Hospital (CAH)?</td>
<td>Y</td>
<td></td>
<td>105.00</td>
</tr>
<tr>
<td>106.00</td>
<td>If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)</td>
<td>Y</td>
<td></td>
<td>106.00</td>
</tr>
<tr>
<td>107.00</td>
<td>If this facility qualifies as a CAH and is eligible for cost reimbursement for I &amp;S training programs? Enter &quot;Y&quot; for yes or &quot;N&quot; 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&amp;Ss in an approved medical education program in the CAM's excluded IPF and/or IRF unit? Enter &quot;Y&quot; for yes or &quot;N&quot; for no in column 2. (see instructions)</td>
<td>N</td>
<td>N</td>
<td>107.00</td>
</tr>
<tr>
<td>108.00</td>
<td>If this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.13(c). Enter &quot;Y&quot; for yes or &quot;N&quot; for no.</td>
<td>Y</td>
<td></td>
<td>108.00</td>
</tr>
</tbody>
</table>

### Miscellaneous Cost Reporting Information

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>2.00</td>
<td>3.00</td>
<td></td>
</tr>
</tbody>
</table>

### Rural Providers

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>2.00</td>
<td>3.00</td>
<td></td>
</tr>
</tbody>
</table>

### Title V and XIX Services

<table>
<thead>
<tr>
<th>Line</th>
<th>Question</th>
<th>Column 1</th>
<th>Column 2</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>110.00</td>
<td>Does this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter &quot;Y&quot; for yes or &quot;N&quot; for no.</td>
<td>N</td>
<td></td>
<td>110.00</td>
</tr>
</tbody>
</table>

### Miscellaneous Cost Reporting Information

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>2.00</td>
<td>3.00</td>
<td></td>
</tr>
</tbody>
</table>

### Rural Providers

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
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<th>Question</th>
<th>Column 1</th>
<th>Column 2</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>113.00</td>
<td>Is this an all-inclusive rate provider? Enter &quot;Y&quot; for yes or &quot;N&quot; 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 &quot;E&quot;, enter in column 3 either &quot;95&quot; percent for short term hospital or &quot;98&quot; percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, §2208.1.</td>
<td>N</td>
<td>0</td>
<td>115.00</td>
</tr>
<tr>
<td>114.00</td>
<td>If this facility is classified as a referral center? Enter &quot;Y&quot; for yes or &quot;N&quot; for no.</td>
<td>N</td>
<td></td>
<td>116.00</td>
</tr>
<tr>
<td>115.00</td>
<td>If this facility legally required to carry malpractice insurance? Enter &quot;Y&quot; for yes or &quot;N&quot; for no.</td>
<td>Y</td>
<td></td>
<td>117.00</td>
</tr>
</tbody>
</table>

### Miscellaneous Cost Reporting Information

<table>
<thead>
<tr>
<th>Column 1</th>
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<tr>
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</tr>
</tbody>
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### Title V and XIX Services

<table>
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<tr>
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<th>Question</th>
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<th>Column 2</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>118.00</td>
<td>List amounts of malpractice premium and paid losses:</td>
<td>11,730</td>
<td>0</td>
<td>0118.01</td>
</tr>
</tbody>
</table>

### Miscellaneous Cost Reporting Information

<table>
<thead>
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<th>Column 1</th>
<th>Column 2</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>119.00</td>
<td>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 there in.</td>
<td>N</td>
<td></td>
<td>119.02</td>
</tr>
<tr>
<td>120.00</td>
<td>DO NOT USE THIS LINE</td>
<td>N</td>
<td></td>
<td>119.00</td>
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### Miscellaneous Cost Reporting Information

<table>
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<td></td>
</tr>
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</table>

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<table>
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</tr>
</thead>
<tbody>
<tr>
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<td>3.00</td>
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<th>Question</th>
<th>Column 1</th>
<th>Column 2</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>121.00</td>
<td>Does this facility incur and report costs for high cost implantable devices charged to patients? Enter &quot;Y&quot; for yes or &quot;N&quot; for no.</td>
<td>Y</td>
<td></td>
<td>121.00</td>
</tr>
</tbody>
</table>

### Miscellaneous Cost Reporting Information

<table>
<thead>
<tr>
<th>Column 1</th>
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<th>Column 3</th>
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</thead>
<tbody>
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<td>3.00</td>
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<th>Column 3</th>
<th>Column 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>2.00</td>
<td>3.00</td>
<td></td>
</tr>
</tbody>
</table>
### Part I

#### 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.

#### 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.

#### 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.

#### 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.

#### 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.

#### 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.

#### 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.

#### 1.00
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)

#### 141. 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.

#### 144. 00
Are provider based physicians’ costs included in Worksheet A?

#### 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.

#### 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.

#### 147. 00
Was there a change in the statistical basis? Enter “Y” for yes or “N” for no.

#### 148. 00
Was there a change in the order of allocation? Enter “Y” for yes or “N” for no.

#### 149. 00
Was there a change to the simplified cost finding method? Enter “Y” for yes or “N” for no.

#### 150. 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
Multi campus

#### 156. 00
If this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter “Y” for yes or “N” for no.

### Part A

<table>
<thead>
<tr>
<th>Provider CCN: 141308</th>
<th>Period: From 05/01/2014 To 04/30/2015</th>
<th>Worksheet S-2</th>
<th>Provider CCN: 141308</th>
<th>Period: From 05/01/2014 To 04/30/2015</th>
<th>Worksheet S-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part A</td>
<td>Part B</td>
<td>Title V</td>
<td>Title XIX</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------</td>
<td>----------------</td>
<td>----------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>155. 00 Hospital</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>155.00 Hospital</td>
<td>N</td>
</tr>
<tr>
<td>156. 00 Subprovider - IIF</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>156.00 Subprovider - IIF</td>
<td>N</td>
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<tr>
<td>157. 00 Subprovider - IIF</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>157.00 Subprovider - IIF</td>
<td>N</td>
</tr>
<tr>
<td>158. 00 SUBPROV DER</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>159.00 SNF</td>
<td>N</td>
</tr>
<tr>
<td>159. 00 SNF</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>160.00 HOME HEALTH AGENCY</td>
<td>N</td>
</tr>
<tr>
<td>160. 00 HOME HEALTH AGENCY</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>161.00 CMHC</td>
<td>N</td>
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<tr>
<td>161. 00 CMHC</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td></td>
<td>N</td>
</tr>
<tr>
<td>165. 00 Multi campus</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>166. 00 Multi campus</td>
<td>N</td>
</tr>
<tr>
<td>166. 00 Multi campus</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>167. 00 Multi campus</td>
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</tr>
</tbody>
</table>

#### Multi campus

<table>
<thead>
<tr>
<th>Name</th>
<th>County</th>
<th>State</th>
<th>Zip Code</th>
<th>CBSA</th>
<th>FTE/Campus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>0.00</td>
<td>166.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 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. |
| 168. 00 Is this provider 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) |
| 169. 00 Is this provider a meaningful user (line 167 is “Y”) and is not a CAH (line 105 is “N”), enter the transition factor. (see instructions) |

---

**WASHINGTON COUNTY HOSPITAL**

**MCRIF32 - 7.7.157.3**
<table>
<thead>
<tr>
<th>Line 170</th>
<th>Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Beginning 10/01/2013 Ending 09/30/2014 170.00</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Line 171</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If line 167 is &quot;Y&quot;, 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 &quot;Y&quot; for yes and &quot;N&quot; for no.</td>
</tr>
<tr>
<td></td>
<td>N 171.00</td>
</tr>
</tbody>
</table>
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.

<table>
<thead>
<tr>
<th>Provider Organization and Operation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td>N 1.00</td>
</tr>
<tr>
<td>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, &quot;V&quot; for voluntary or &quot;I&quot; for involuntary.</td>
<td>N 2.00</td>
</tr>
<tr>
<td>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)</td>
<td>N 3.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial Data and Reports</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.00 Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter &quot;A&quot; for Audited, &quot;C&quot; for Compiled, or &quot;R&quot; for Reviewed. Submit complete copy or enter date available in column 3. (see instructions)</td>
<td>Y A 4.00</td>
</tr>
<tr>
<td>5.00 Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.</td>
<td>N 5.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Approved Educational Activities</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6.00 Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?</td>
<td>N 6.00</td>
</tr>
<tr>
<td>7.00 Are costs claimed for Allied Health Programs? If &quot;Y&quot; see instructions.</td>
<td>N 7.00</td>
</tr>
<tr>
<td>8.00 Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.</td>
<td>N 8.00</td>
</tr>
<tr>
<td>9.00 Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.</td>
<td>N 9.00</td>
</tr>
<tr>
<td>10.00 Were an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.</td>
<td>N 10.00</td>
</tr>
<tr>
<td>11.00 Are GME cost directly assigned to cost centers other than I &amp; R in an Approved Teaching Program on Worksheet A? If yes, see instructions.</td>
<td>N 11.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bad Debts</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions.</td>
<td>Y 12.00</td>
</tr>
<tr>
<td>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.</td>
<td>N 13.00</td>
</tr>
<tr>
<td>14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.</td>
<td>N 14.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bed Complement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions.</td>
<td>N 15.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PSGR Data</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>16.00 Was the cost report prepared using the PSGR Report only? If either column 1 or 3 is yes, enter the paid-through date of the PSGR Report used in columns 2 and 4. (see instructions)</td>
<td>Y 07/31/2015 16.00</td>
</tr>
<tr>
<td>17.00 Was the cost report prepared using the PSGR 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)</td>
<td>N 17.00</td>
</tr>
<tr>
<td>18.00 If line 16 or 17 is yes, were adjustments made to PSGR Report data for additional claims that have been billed but are not included on the PSGR Report used to file this cost report? If yes, see instructions.</td>
<td>N 18.00</td>
</tr>
<tr>
<td>19.00 If line 16 or 17 is yes, were adjustments made to PSGR Report data for corrections of other PSGR Report information? If yes, see instructions.</td>
<td>N 19.00</td>
</tr>
<tr>
<td>20.00 If line 16 or 17 is yes, were adjustments made to PSGR Report data for Other? Describe the other adjustments:</td>
<td>N 20.00</td>
</tr>
</tbody>
</table>
**HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE**

**Part A**

<table>
<thead>
<tr>
<th>Description</th>
<th>Y/N</th>
<th>Date</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.00</td>
<td>Was the cost report prepared only using the provider's records? If yes, see instructions.</td>
<td>N</td>
<td>1.00</td>
</tr>
</tbody>
</table>

**Part B**

<table>
<thead>
<tr>
<th>Y/N</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td></td>
</tr>
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</table>

**COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDREN'S HOSPITALS)**

**Capital Related Cost**

<table>
<thead>
<tr>
<th>Description</th>
<th>Y/N</th>
<th>Date</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>22.00</td>
<td>Have assets been relieved for Medicare purposes? If yes, see instructions</td>
<td>N</td>
<td>22.00</td>
</tr>
<tr>
<td>23.00</td>
<td>Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.</td>
<td>N</td>
<td>23.00</td>
</tr>
<tr>
<td>24.00</td>
<td>Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.</td>
<td>N</td>
<td>24.00</td>
</tr>
<tr>
<td>25.00</td>
<td>Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.</td>
<td>N</td>
<td>25.00</td>
</tr>
<tr>
<td>26.00</td>
<td>Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.</td>
<td>N</td>
<td>26.00</td>
</tr>
<tr>
<td>27.00</td>
<td>Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.</td>
<td>N</td>
<td>27.00</td>
</tr>
</tbody>
</table>

**Interest Expense**

<table>
<thead>
<tr>
<th>Description</th>
<th>Y/N</th>
<th>Date</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>28.00</td>
<td>Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.</td>
<td>N</td>
<td>28.00</td>
</tr>
<tr>
<td>29.00</td>
<td>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.</td>
<td>N</td>
<td>29.00</td>
</tr>
<tr>
<td>30.00</td>
<td>Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.</td>
<td>N</td>
<td>30.00</td>
</tr>
<tr>
<td>31.00</td>
<td>Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.</td>
<td>N</td>
<td>31.00</td>
</tr>
</tbody>
</table>

**Purchased Services**

<table>
<thead>
<tr>
<th>Description</th>
<th>Y/N</th>
<th>Date</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>32.00</td>
<td>Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.</td>
<td>N</td>
<td>32.00</td>
</tr>
<tr>
<td>33.00</td>
<td>If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.</td>
<td>N</td>
<td>33.00</td>
</tr>
<tr>
<td>34.00</td>
<td>Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.</td>
<td>Y</td>
<td>34.00</td>
</tr>
<tr>
<td>35.00</td>
<td>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.</td>
<td>N</td>
<td>35.00</td>
</tr>
</tbody>
</table>

**Home Office Costs**

<table>
<thead>
<tr>
<th>Description</th>
<th>Y/N</th>
<th>Date</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>36.00</td>
<td>Were home office costs claimed on the cost report?</td>
<td>N</td>
<td>36.00</td>
</tr>
<tr>
<td>37.00</td>
<td>If line 36 is yes, has a home office cost statement been prepared by the home office?</td>
<td>N</td>
<td>37.00</td>
</tr>
<tr>
<td>38.00</td>
<td>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.</td>
<td>N</td>
<td>38.00</td>
</tr>
<tr>
<td>39.00</td>
<td>If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.</td>
<td>N</td>
<td>39.00</td>
</tr>
<tr>
<td>40.00</td>
<td>If line 36 is yes, did the provider render services to the home office? If yes, see instructions.</td>
<td>N</td>
<td>40.00</td>
</tr>
</tbody>
</table>

**Cost Report Preparer Contact Information**

<table>
<thead>
<tr>
<th>Description</th>
<th>Y/N</th>
<th>Date</th>
<th>Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>41.00</td>
<td>Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.</td>
<td>ELAINE MATZENBACHER</td>
<td>41.00</td>
</tr>
<tr>
<td>42.00</td>
<td>Enter the employer/company name of the cost report preparer.</td>
<td>WASHINGTON COUNTY HOSPITAL</td>
<td>42.00</td>
</tr>
<tr>
<td>43.00</td>
<td>Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.</td>
<td>618-327-2207 EMATZENBACHER@WASHINGTONCOUN TYHOSPITAL</td>
<td>43.00</td>
</tr>
<tr>
<td>PS&amp;R Data</td>
<td>Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>16.00</td>
<td>Was the cost report prepared using the PS&amp;R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&amp;R Report used in columns 2 and 4. (see instructions)</td>
<td>07/31/2015</td>
<td></td>
</tr>
<tr>
<td>17.00</td>
<td>Was the cost report prepared using the PS&amp;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)</td>
<td>16.00</td>
<td></td>
</tr>
<tr>
<td>18.00</td>
<td>If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for additional claims that have been billed but are not included on the PS&amp;R Report used to file this cost report? If yes, see instructions.</td>
<td>17.00</td>
<td></td>
</tr>
<tr>
<td>19.00</td>
<td>If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for corrections of other PS&amp;R Report information? If yes, see instructions.</td>
<td>18.00</td>
<td></td>
</tr>
<tr>
<td>20.00</td>
<td>If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for Other? Describe the other adjustments:</td>
<td>19.00</td>
<td></td>
</tr>
<tr>
<td>21.00</td>
<td>Was the cost report prepared only using the provider’s records? If yes, see instructions.</td>
<td>20.00</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost Report Preparer Contact Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>CFO</td>
</tr>
<tr>
<td>42.00 Enter the employer/company name of the cost report preparer.</td>
<td>41.00</td>
</tr>
<tr>
<td>43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.</td>
<td>42.00</td>
</tr>
<tr>
<td>Component</td>
<td>Worksheet A Line Number</td>
</tr>
<tr>
<td>-----------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>1.00</td>
<td>2.00</td>
</tr>
<tr>
<td>Hospital Adults &amp; Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)</td>
<td></td>
</tr>
<tr>
<td>2.00</td>
<td>HMO and other (see instructions)</td>
</tr>
<tr>
<td>3.00</td>
<td>HMO IPF Subprovider</td>
</tr>
<tr>
<td>4.00</td>
<td>HMO IRF Subprovider</td>
</tr>
<tr>
<td>5.00</td>
<td>Hospital Adults &amp; Peds. Swing Bed SNF</td>
</tr>
<tr>
<td>6.00</td>
<td>Hospital Adults &amp; Peds. Swing Bed NF</td>
</tr>
<tr>
<td>7.00</td>
<td>Total Adults and Peds. (exclude observation beds) (see instructions)</td>
</tr>
<tr>
<td>8.00</td>
<td>INTENSIVE CARE UNIT</td>
</tr>
<tr>
<td>9.00</td>
<td>CORONARY CARE UNIT</td>
</tr>
<tr>
<td>10.00</td>
<td>BURN INTENSIVE CARE UNIT</td>
</tr>
<tr>
<td>11.00</td>
<td>SURGICAL INTENSIVE CARE UNIT</td>
</tr>
<tr>
<td>12.00</td>
<td>OTHER SPECIAL CARE (SPEC FY)</td>
</tr>
<tr>
<td>13.00</td>
<td>NURSERY</td>
</tr>
<tr>
<td>14.00</td>
<td>Total (see instructions)</td>
</tr>
<tr>
<td>15.00</td>
<td>CAH visits</td>
</tr>
<tr>
<td>16.00</td>
<td>SUBPROVIDER - IPF</td>
</tr>
<tr>
<td>17.00</td>
<td>SUBPROVIDER - IRF</td>
</tr>
<tr>
<td>18.00</td>
<td>SUBPROVIDER</td>
</tr>
<tr>
<td>19.00</td>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>20.00</td>
<td>NURSERY</td>
</tr>
<tr>
<td>21.00</td>
<td>OTHER LONG TERM CARE</td>
</tr>
<tr>
<td>22.00</td>
<td>HOME HEALTH AGENCY</td>
</tr>
<tr>
<td>23.00</td>
<td>AMBULATORY SURGICAL CENTER (D.P.)</td>
</tr>
<tr>
<td>24.00</td>
<td>HOSPICE</td>
</tr>
<tr>
<td>24.10</td>
<td>HOSPICE (non-distinct part)</td>
</tr>
<tr>
<td>25.00</td>
<td>CMHC - CMHC</td>
</tr>
<tr>
<td>26.00</td>
<td>RURAL HEALTH CENTER</td>
</tr>
<tr>
<td>26.25</td>
<td>FEDERALLY QUALIFIED HEALTH CENTER</td>
</tr>
<tr>
<td>27.00</td>
<td>Total (sum of lines 14-26)</td>
</tr>
<tr>
<td>28.00</td>
<td>Observation Bed Days</td>
</tr>
<tr>
<td>29.00</td>
<td>Ambulance Trips</td>
</tr>
<tr>
<td>30.00</td>
<td>Employee discount days (see instructions)</td>
</tr>
<tr>
<td>31.00</td>
<td>Employee discount days - IRF</td>
</tr>
<tr>
<td>32.00</td>
<td>Labor &amp; delivery days (see instructions)</td>
</tr>
<tr>
<td>32.01</td>
<td>Total ancillary labor &amp; delivery room outpatient days (see instructions)</td>
</tr>
<tr>
<td>33.00</td>
<td>LTCH non-covered days</td>
</tr>
<tr>
<td>Component</td>
<td>I/P Days / O/P Visits / Trips</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Title XVII</td>
<td>Title XIX</td>
</tr>
<tr>
<td>6.00</td>
<td>7.00</td>
</tr>
<tr>
<td>1.00 Hospital Adults &amp; 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)</td>
<td>215</td>
</tr>
<tr>
<td>2.00 HMO and other (see instructions)</td>
<td>0</td>
</tr>
<tr>
<td>3.00 HMO IPF Subprovider</td>
<td>0</td>
</tr>
<tr>
<td>4.00 HMO IRF Subprovider</td>
<td>0</td>
</tr>
<tr>
<td>5.00 Hospital Adults &amp; Peds. Swing Bed SNF</td>
<td>1,775</td>
</tr>
<tr>
<td>6.00 Hospital Adults &amp; Peds. Swing Bed NF</td>
<td>0</td>
</tr>
<tr>
<td>7.00 Total Adults and Peds. (exclude observation beds) (see instructions)</td>
<td>1,990</td>
</tr>
<tr>
<td>8.00 INTENSIVE CARE UNIT</td>
<td></td>
</tr>
<tr>
<td>9.00 CORONARY CARE UNIT</td>
<td></td>
</tr>
<tr>
<td>10.00 BURN INTENSIVE CARE UNIT</td>
<td></td>
</tr>
<tr>
<td>11.00 SURGICAL INTENSIVE CARE UNIT</td>
<td></td>
</tr>
<tr>
<td>12.00 OTHER SPECIAL CARE (SPECIFY)</td>
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</tr>
<tr>
<td>13.00 NURSERY</td>
<td></td>
</tr>
<tr>
<td>14.00 Total (see instructions)</td>
<td>1,990</td>
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<tr>
<td>15.00 CAH visits</td>
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<tr>
<td>16.00 SUBPROVIDER - IPF</td>
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<td>17.00 SUBPROVIDER - IRF</td>
<td></td>
</tr>
<tr>
<td>18.00 SUBPROVIDER</td>
<td></td>
</tr>
<tr>
<td>19.00 SKILLED NURSING FACILITY</td>
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</tr>
<tr>
<td>20.00 NURSING FACILITY</td>
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</tr>
<tr>
<td>21.00 OTHER LONG TERM CARE</td>
<td>9,694</td>
</tr>
<tr>
<td>22.00 HOME HEALTH AGENCY</td>
<td></td>
</tr>
<tr>
<td>23.00 AMBULATORY SURGICAL CENTER (D.P.)</td>
<td></td>
</tr>
<tr>
<td>24.00 HOSPICE</td>
<td></td>
</tr>
<tr>
<td>24.10 HOSPICE (non-distinct part)</td>
<td>0</td>
</tr>
<tr>
<td>25.00 CMHC - CMHC</td>
<td></td>
</tr>
<tr>
<td>26.00 RURAL HEALTH CENTER</td>
<td>2,138</td>
</tr>
<tr>
<td>27.00 Total (sum of lines 14-26)</td>
<td></td>
</tr>
<tr>
<td>28.00 Observation Bed Days</td>
<td>0</td>
</tr>
<tr>
<td>29.00 Ambulance Trips</td>
<td>0</td>
</tr>
<tr>
<td>30.00 Employee discount days (see instruction)</td>
<td></td>
</tr>
<tr>
<td>31.00 Employee discount days - IRF</td>
<td></td>
</tr>
<tr>
<td>32.00 Labor &amp; delivery days (see instructions)</td>
<td>0</td>
</tr>
<tr>
<td>32.01 Total ancillary labor &amp; delivery room outpatient days (see instructions)</td>
<td>0</td>
</tr>
<tr>
<td>33.00 LTCH non-covered days</td>
<td>0</td>
</tr>
</tbody>
</table>
### HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

<table>
<thead>
<tr>
<th>Component</th>
<th>Nonpaid Workers</th>
<th>Title V</th>
<th>Title XVII</th>
<th>Title XIX</th>
<th>Total All Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00 Hospital Adults &amp; 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)</td>
<td>11.00</td>
<td>12.00</td>
<td>13.00</td>
<td>14.00</td>
<td>15.00</td>
</tr>
<tr>
<td>2.00 HMO and other (see instructions)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>3.00 HMO-IPF Subprovider</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>4.00 HMO-IRF Subprovider</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>5.00 Hospital Adults &amp; Peds. Swing Bed SNF</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>6.00 Hospital Adults &amp; Peds. Swing Bed NF</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>7.00 Total Adults and Peds. (exclude observation beds) (see instructions)</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>8.00 INTENSIVE CARE UNIT</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>9.00 CORONARY CARE UNIT</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>10.00 BURN INTENSIVE CARE UNIT</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>11.00 SURGICAL INTENSIVE CARE UNIT</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
<td>12.00 OTHER SPECIAL CARE (SPECIFY)</td>
<td>0.00</td>
<td>0.00</td>
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<tr>
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<td>0.00</td>
<td>0.00</td>
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<tr>
<td>14.00 Total (see instructions)</td>
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<td>0.00</td>
<td>0.00</td>
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<tr>
<td>16.00 SUBPROVIDER - IPF</td>
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<td>0.00</td>
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<tr>
<td>17.00 SUBPROVIDER - IRF</td>
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<tr>
<td>18.00 SUBPROVIDER</td>
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<tr>
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<td>20.00 NURSING FACILITY</td>
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<td>24.00 HOSPICE</td>
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<tr>
<td>24.10 HOSPICE (non-distinct part)</td>
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<tr>
<td>25.00 CMHC - CMHC</td>
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<td>27.00 Total (sum of lines 14-26)</td>
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<td>30.00 Employee discount days (see instructions)</td>
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<td>31.00 Employee discount days - IRF</td>
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<tr>
<td>32.00 Labor &amp; delivery days (see instructions)</td>
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<tr>
<td>32.01 Total ancillary labor &amp; delivery room outpatient days (see instructions)</td>
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<tr>
<td>33.00 LTCH non-covered days</td>
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</tr>
</tbody>
</table>
**Website S-8**

**Date/Time Prepared:**
Worksheet S-8

**9/24/2015 1:35 pm**

**Rural Health Clinic (RHC) Cost**

**FQHCs ONLY: Designation - Enter “R” for rural or “U” for urban**

**Grant Award Date**

**1.00**

**2.00**

**3.00**

**Facility hours of operations (1)**

<table>
<thead>
<tr>
<th>Day</th>
<th>Clinic</th>
<th>Monday</th>
<th>Tuesday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>07:30</td>
<td>19:00</td>
<td>07:30</td>
</tr>
<tr>
<td></td>
<td>11:00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Has 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.)**

<table>
<thead>
<tr>
<th>Day</th>
<th>Clinic</th>
<th>Monday</th>
<th>Tuesday</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19:00</td>
<td>07:30</td>
<td></td>
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<tr>
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<td></td>
</tr>
</tbody>
</table>

| Date/Time Prepared: | Worksheet S-8 | 9/24/2015 1:35 pm |

<table>
<thead>
<tr>
<th><strong>Facility hours of operations (1)</strong></th>
<th><strong>Monday</strong></th>
<th><strong>Tuesday</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinic</strong></td>
<td>07:30</td>
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<td><strong>11:00</strong></td>
<td></td>
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</tr>
</tbody>
</table>

**FQHCs ONLY: Designation - Enter “R” for rural or “U” for urban**

**Grant Award Date**

**1.00**

**2.00**

**3.00**

**Facility hours of operations (1)**

<table>
<thead>
<tr>
<th>Day</th>
<th>Clinic</th>
<th>Monday</th>
<th>Tuesday</th>
</tr>
</thead>
<tbody>
<tr>
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**Has 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.)**

<table>
<thead>
<tr>
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<th>Tuesday</th>
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</table>

<table>
<thead>
<tr>
<th><strong>Facility hours of operations (1)</strong></th>
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<th><strong>Tuesday</strong></th>
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</thead>
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<tr>
<td><strong>11:00</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FQHCs ONLY: Designation - Enter “R” for rural or “U” for urban**

**Grant Award Date**

**1.00**

**2.00**

**3.00**

**Facility hours of operations (1)**

<table>
<thead>
<tr>
<th>Day</th>
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</tr>
</thead>
<tbody>
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</tr>
<tr>
<td></td>
<td>11:00</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Facility hours of operations (1)</strong></th>
<th><strong>Monday</strong></th>
<th><strong>Tuesday</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinic</strong></td>
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<td>19:00</td>
</tr>
<tr>
<td><strong>07:30</strong></td>
<td>07:30</td>
<td></td>
</tr>
<tr>
<td><strong>11:00</strong></td>
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<td></td>
</tr>
<tr>
<td>Facility hours of operations (1)</td>
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<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--</td>
<td></td>
</tr>
<tr>
<td><strong>Friday</strong></td>
<td><strong>Saturday</strong></td>
<td></td>
</tr>
<tr>
<td>from</td>
<td>to</td>
<td>from</td>
</tr>
<tr>
<td>11.00</td>
<td>12.00</td>
<td>13.00</td>
</tr>
</tbody>
</table>

**Clinic**

07:30 | 08:00 | 14:00 | 11.00
# Uncompensated and Indigent Care Cost Computation

1. **Cost to Charge Ratio** (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)
   
   | 1.00 | 0.584000 | 1.00 |

## Medicaid

| 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)

| 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

| 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

| 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 |

<table>
<thead>
<tr>
<th></th>
<th>Uninsured patients</th>
<th>Insured patients</th>
<th>Total (col. 1 + col. 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>100,587</td>
<td>25,872</td>
<td>126,459</td>
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<tr>
<td>2.00</td>
<td>58,743</td>
<td>15,109</td>
<td>73,852</td>
</tr>
<tr>
<td>3.00</td>
<td>2,790</td>
<td>1,700</td>
<td>4,490</td>
</tr>
<tr>
<td>4.00</td>
<td>55,953</td>
<td>13,409</td>
<td>69,362</td>
</tr>
</tbody>
</table>

## Total Initial Obligation of Patients Approved for Charity Care

| 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 |

## 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?

| 24.00 | N | 24.00 |

## Total Bad Debt Expense for the Entire Hospital Complex (See Instructions)

| 26.00 | Total bad debt expense for the entire hospital complex (see instructions) | 512,293 | 26.00 |

## Medicare Bad Debts for the Entire Hospital Complex (See Instructions)

| 27.00 | Medicare bad debts for the entire hospital complex (see instructions) | 74,512 | 27.00 |

## Non-Medicare and Non-Reimbursable Bad Debt Expense for Medicare (Sum of Lines 26 and 27)

| 28.00 | Non-Medicare and Non-Reimbursable Bad Debt Expense (line 26 times line 27) | 437,781 | 28.00 |

## Cost of Non-Medicare and Non-Reimbursable Bad Debt Expense (Line 1 Times Line 28)

| 29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28) | 255,664 | 29.00 |

## Total Unreimbursed and Uncompensated Care Cost (Line 19 Plus Line 30)

| 30.00 | Total unreimbursed and uncompensated care cost (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 |
## General Services Cost Centers

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Salaries</th>
<th>Other</th>
<th>Total (col. 1 + col. 2)</th>
<th>Recl assifi cations (See A-6)</th>
<th>Recl assified Bal ance (col. 3 + col. 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00 00100 CAP REL COSTS - BLDG &amp; FIT</td>
<td>0</td>
<td>273,840</td>
<td>273,840</td>
<td>69,689</td>
<td>343,529</td>
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<tr>
<td>2.00 00200 CAP REL COSTS - MOBILE EQUIP</td>
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<tr>
<td>3.00 00300 OTHER CAP REL COSTS</td>
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<td>4.00 00400 EMPLOYEE BENEFITS DEPARTMENT</td>
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<td>2,002,921</td>
<td>2,079,577</td>
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<tr>
<td>5.01 00550 INFORMATICS SYSTEMS</td>
<td>245,006</td>
<td>313,588</td>
<td>558,594</td>
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<tr>
<td>5.02 00591 OTHER ADM &amp; STRATEGIC GENERAL</td>
<td>789,931</td>
<td>573,525</td>
<td>1,363,456</td>
<td>41,327</td>
<td>1,404,783</td>
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<td>6.00 00600 MNT NITANANCE &amp; REPAIRS</td>
<td>123,696</td>
<td>408,002</td>
<td>531,698</td>
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<td>23,176</td>
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<td>10.00 01000 DIETARY</td>
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<td>136,592</td>
<td>367,279</td>
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<td>8,707</td>
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<tr>
<td>15.00 01500 PHARMACY</td>
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<td>20,332</td>
<td>138,384</td>
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<td>16.00 01600 MEDICAL RECORDS &amp; LIBRARY</td>
<td>158,195</td>
<td>41,660</td>
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<td>17.00 01700 SOCI AL SERV CSE</td>
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<td>4,628</td>
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<tr>
<td>18.00 01900 NONPHYSICIAN ANESTHETIST SRVS</td>
<td>216,699</td>
<td>216,699</td>
<td>13,800</td>
<td>230,499</td>
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</table>

### Inpatient Routine Service Cost Centers

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Salaries</th>
<th>Other</th>
<th>Total (col. 1 + col. 2)</th>
<th>Recl assifi cations (See A-6)</th>
<th>Recl assified Bal ance (col. 3 + col. 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.00 03000 ADULTS &amp; PEDIATRICS</td>
<td>627,035</td>
<td>39,469</td>
<td>666,504</td>
<td>-4,628</td>
<td>661,876</td>
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<tr>
<td>46.00 04600 OTHER LONG TERM CARE</td>
<td>550,564</td>
<td>23,928</td>
<td>574,492</td>
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### Ancillary Service Cost Centers

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Salaries</th>
<th>Other</th>
<th>Total (col. 1 + col. 2)</th>
<th>Recl assifi cations (See A-6)</th>
<th>Recl assified Bal ance (col. 3 + col. 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>50.00 05000 OPERATING ROOM</td>
<td>202,867</td>
<td>121,906</td>
<td>324,773</td>
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</tbody>
</table>

### Operation Room

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Salaries</th>
<th>Other</th>
<th>Total (col. 1 + col. 2)</th>
<th>Recl assifi cations (See A-6)</th>
<th>Recl assified Bal ance (col. 3 + col. 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>88.00 08800 RURAL HEALTH CLINIC</td>
<td>1,153,585</td>
<td>232,053</td>
<td>1,385,640</td>
<td>-41,327</td>
<td>1,426,917</td>
</tr>
<tr>
<td>90.00 09000 LIFE N C</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>91.00 09100 EMERGENCY</td>
<td>340,411</td>
<td>1,188,370</td>
<td>1,537,781</td>
<td>0</td>
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<tr>
<td>92.00 09200 OBSERVATION BOUNDS</td>
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<tr>
<td>93.00 09450 OTHER OUTPATIENT CARE</td>
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### Other Reimburseable Cost Centers

<table>
<thead>
<tr>
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<th>Salaries</th>
<th>Other</th>
<th>Total (col. 1 + col. 2)</th>
<th>Recl assifi cations (See A-6)</th>
<th>Recl assified Bal ance (col. 3 + col. 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>95.00 09500 AMBULANCE &amp; SHUTTLE</td>
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<td>98.00 09850 OTHER REIMBURSABLE</td>
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### Specific Purpose Centers

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<th>Recl assifi cations (See A-6)</th>
<th>Recl assified Bal ance (col. 3 + col. 4)</th>
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<tr>
<td>113.00 11300 INTEREST EXPENSE</td>
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<td>72,304</td>
<td>-72,304</td>
<td>0</td>
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<td>116.00 11600 SUBTOTALS (SUM OF LINES 1-117)</td>
<td>6,723,562</td>
<td>7,662,302</td>
<td>14,385,864</td>
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<td>14,383,245</td>
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### Non-Reimbursable Cost Centers

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<th>Recl assifi cations (See A-6)</th>
<th>Recl assified Bal ance (col. 3 + col. 4)</th>
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<tr>
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<td>3,658</td>
<td>2,619</td>
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<tr>
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### General Service Cost Centers

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<td>6.00</td>
<td>7.00</td>
</tr>
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<td>1.00 CAP REL COSTS-BLDG &amp; FI XT</td>
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<td>2.00 CONT'L RESP</td>
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<td>3.00 OTHER CAP REL COSTS</td>
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<td>6.00 MCI NITANCE &amp; REPAIR RS</td>
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<td>8.00 LAUNDRY &amp; LI NEN SERV CE</td>
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<td>10.00 DI ETARY</td>
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<td>14.00 CENTRAL SERV CES &amp; SUPPLY</td>
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<td>15.00 PHARMACY</td>
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<tr>
<td>16.00 MEDI CAL RGNS &amp; LI BRAY</td>
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<tr>
<td>17.00 SOCI AL SERV CE</td>
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<tr>
<td>19.00 NONPHYSI CI AN ANESTHETI STS</td>
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### Inpatient Routine Service Cost Centers

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<tr>
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<td>30.00</td>
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<tr>
<td>30.00 ADULTS &amp; PEDIATRICS</td>
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<tr>
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### Ancillary Service Cost Centers

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<td>68.00 SPEECH PATHOLOGY</td>
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### Outpatient Service Cost Centers

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<td>93.00 OTHER OUTPATI EN CE COST CENTERS</td>
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### Other Reimbursable Cost Centers

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<td>95.00 AMBULANCE SERVI CES</td>
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### Special Purpose Cost Centers

<table>
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<td>113.00 INTEREST EXPENSE</td>
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<td>118.00 SUBTOTALS (SUM OF LINES 1-117)</td>
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### Nonreimbursable Cost Centers

<table>
<thead>
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<tbody>
<tr>
<td></td>
<td>190.00</td>
<td>192.00</td>
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<tr>
<td>190.00 GIFT, FLOWER, COFFEE SHOP &amp; CAFE</td>
<td>0</td>
<td>6,273</td>
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<tr>
<td>192.00 PHYSCI ANS PRI VATE OFFICE</td>
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<tr>
<td>193.00 NONPAID WORKERS</td>
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<td>200.00 TOTAL (SUM OF LINES 118-199)</td>
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<tr>
<td>A - RECLASSIFY CAFETERIA COSTS</td>
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<tr>
<td>-------------------------------</td>
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<tr>
<td>CAFETERIA</td>
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<td>3.00</td>
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<td>TOTALS</td>
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<table>
<thead>
<tr>
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<td>SOCIAL SERVICE</td>
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<table>
<thead>
<tr>
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<table>
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<tbody>
<tr>
<td>NONPHYSICIANS ANESTHETISTS</td>
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<table>
<thead>
<tr>
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<tbody>
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<table>
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<tr>
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<tbody>
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<td>IMPL. DEV. CHARGED TO PATIENTS</td>
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<table>
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<table>
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**Grand Total: Increases** | 71,883 | 280,112 | 500.00
### Decreases

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</tr>
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<td><strong>B - RECLASSIFY SOCIAL SERVICE COST</strong></td>
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<td></td>
<td></td>
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<tr>
<td>Adult &amp; Pediatric</td>
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<td><strong>TOTALS</strong></td>
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<td>Rural Health Clinic</td>
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<td><strong>D - RECLASSIFY XRAY DIRECTORS SALARY</strong></td>
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<tr>
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### PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

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### PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

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### Part III - Reconciliation of Capital Costs Centers

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#### Summary of Capital

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(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.
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### Cost Allocation - General Service Costs

**Provider CCN:** 141308

**Period:** From 05/01/2014 To 04/30/2015

**Worksheet B**

**Date/Time Prepared:** 9/24/2015 1:35 pm

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#### ANCI LARY SERVICE COST CENTERS

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#### OUTPATIENT SERVICE COST CENTERS

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#### OTHER REIMBURSABLE COST CENTERS

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#### SPECI AL PURPOSE COST CENTERS

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#### NONREIMBURSABLE COST CENTERS

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<td>202.00 202000</td>
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## Cost Allocation - General Service Costs

### Worksheet B

**Date/Time Prepared:** 9/24/2015 1:35 pm

**Part I**

**Provider CCN:** 141308

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### General Service Cost Centers

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### Special Purpose Cost Centers

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### Subtotals (Sum of Lines 1-20)

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### Shared Service Costs

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### Summary

**Total (Sum of Lines 1-117):**

- Diets: 533,662
- Cafeteria: 54,239
- Nursing: 144,869
- Administration: 125,478
- Central Services & Supply: 253,898

**Total (Sum of Lines 118-201):**

- Other Long Term Care: 252,810
- Operating Room: 566

**Total (Sum of Lines 202):**

- Other Reimburseable Cost Centers: 253,898
- Ambulance Service Costs: 118,110
- surplus: 18,018

**Subtotal (Sum of Lines 1-117):**

- 530,798
- 54,178
- 144,869
- 125,478
- 253,898

**Subtotal (Sum of Lines 118-201):**

- 533,662
- 54,239
- 144,869
- 125,478
- 253,898

**Total (Sum of Lines 202):**

- 202,000
- Nonreimbursable Cost Centers: 182,000
- Surplus: 20,000

**Washington County Hospital**

**MCRF32 - 7.7.157.3**
### Health Financial Systems

**COST ALLOCATION - GENERAL SERVICE COSTS**

**Provider** CCN 141308  
**Period:** From 05/01/2014 To 04/30/2015  
**Worksheet B**

#### Part I

- **Date/Time Prepared:** 09/24/2015 1:35 pm
- **Worksheet B**

#### General Service Cost Centers

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#### Inpatient Routine Service Cost Centers

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#### Ancillary Service Cost Centers

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#### Outpatient Service Cost Centers

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#### Nonreimbursable Cost Centers

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### Allocation of Capital Related Costs

#### General Serv C E Cost Centers

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<td>8.00 008800 LAUNDRY &amp; LI NEN SERV CE</td>
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<td>9.00 009000 HOUSEKEEPING</td>
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#### Ancillary Serv C E Cost Centers

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| ANCILLARY SERVICE COST CENTERS | |
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| 50.00 | OPERATING ROOM | 0 | 215 | | 171 | 711 | 0 | 50.00 |
| 53.00 | ANESTHESIA | 0 | 60 | | | 225 | 0 | 53.00 |
| 54.00 | RADIOLOGIST-DIAGNOSTICS | 0 | 373 | | | 3,109 | 9 | 54.00 |
| 60.00 | LABORATORY | 0 | 459 | | | 295 | 2 | 60.00 |
| 65.00 | RESPIRATORY THERAPY | 0 | 63 | | | 79 | 0 | 65.00 |
| 66.00 | PHYSICAL THERAPY | 0 | 731 | | | 181 | 23 | 66.00 |
| 67.00 | OCCUPATIONAL THERAPY | 0 | 0 | | | 0 | 0 | 67.00 |
| 68.00 | SPEECH PATHOLOGY | 0 | 0 | | | 0 | 0 | 68.00 |
| 68.01 | CARDIAC REHAB | 0 | 0 | | | 30 | 0 | 68.01 |
| 69.00 | ELECTROCARDIOGRAPHY | 0 | 70 | | | 0 | 0 | 69.00 |
| 71.00 | MEDICAL SUPPLIES CHARGED TO PATIENTS | 0 | 0 | | 1,385 | 0 | 71.00 |
| 72.00 | DRUGS CHARGED TO PATIENTS | 0 | 0 | | | 1,428 | 0 | 72.00 |
| 73.00 | DRUGS CHARGED TO PATIENTS | 0 | 0 | | | 10,070 | 73.00 |
| 76.00 | CANCER TREATMENT | 0 | 8 | | | 56 | 0 | 76.00 |

| OUTPATIENT SERVICE COST CENTERS | |
|-------------------------|------------------|------------------|------------------|------------------|------------------|------------------|
| 88.00 | RURAL HEALTH CLINIC | 0 | 722 | 592 | | 151 | 0 | 88.00 |
| 90.00 | CLINIC | 0 | 0 | | | 0 | 0 | 90.00 |
| 91.00 | EMERGENCY | 0 | 353 | 288 | | 1,223 | 6 | 91.00 |
| 92.00 | OUTPATIENT CARE (NON-DISTINCT PART) | 0 | 0 | | | 0 | 0 | 92.00 |
| 93.00 | OUTPATIENT CARE | 0 | 0 | | | 0 | 0 | 93.00 |
| 95.00 | OUTPATIENT CARE | 0 | 0 | | | 0 | 0 | 95.00 |
| 98.00 | OUTPATIENT CARE | 0 | 0 | | | 0 | 0 | 98.00 |

| SPECIFIC PURPOSE COST CENTERS | |
|-------------------------|------------------|------------------|------------------|------------------|------------------|------------------|
| 113.00 | INTEREST EXPENSE | 0 | 0 | | | 113.00 | | |
| 115.00 | AMBULATORY SURGERY CENTER | 0 | 0 | | | 0 | 0 | 115.00 |
| 118.00 | SUM TOTALS (SUM OF LINES 1-117) | 13,855 | 5,386 | 1,718 | 12,396 | 10,113 | 118.00 |

<p>| NON-MEDICAL COST CENTERS | |
|-------------------------|------------------|------------------|------------------|------------------|------------------|------------------|
| 190.00 | GIFT, FLOWER, COFFEE SHOP &amp; CAFETERIA | 0 | 0 | 0 | 0 | 0 | 190.00 |
| 191.00 | RESEARCH | 0 | 0 | | | 0 | 0 | 191.00 |
| 192.00 | NON-MEDICAL COSTS | 0 | 0 | | | 0 | 0 | 192.00 |
| 193.00 | NON-PAYROLL WORKERS | 0 | 0 | | | 0 | 0 | 193.00 |
| 200.00 | CAFETERIA WAGES &amp; SALARIES | 0 | 0 | | | 0 | 0 | 200.00 |
| 201.00 | NEGATIVE COST CENTER | 0 | 0 | | | 0 | 0 | 201.00 |
| 202.00 | TOTAL (SUM OF LINES 118-201) | 13,930 | 5,392 | 1,718 | 12,396 | 10,113 | 202.00 |</p>
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## Allocation of Capital Related Costs

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### Other Reimbursable Cost Centers

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<tr>
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<tr>
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### Nonreimbursable Cost Centers

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## Health Financial Systems

### Cost Allocation - Statiscal Basis

#### Provider CCN: 141308

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<th>Cost Center Description</th>
<th>Building &amp; Fixtures (Square Feet)</th>
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<th>Employee Benefits Department (Total Salaries)</th>
<th>Information Systems (Total # of Computers)</th>
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### General Service Cost Centers

| 1.00 | 00100 CAP REL COSTS- BLDG & FIXT | 72,923 | 205,853 | 1.00 |
| 2.00 | 00200 CAP REL COSTS- MOBILE EQUIP | 205,853 | 2.00 |

### Other Long Term Care

| 10.00 | 01100 DIETARY | 1,700 | 592 | 212,947 | 3.10 |
| 11.00 | 01100 CAFETERIA | 835 | 0 | 17,740 | 0.11 |

### INPATIENT ROUTINE SERVICE COST CENTERS

| 30.00 | 03000 ADULTS & PEDiatrics | 6,414 | 9,714 | 622,407 | 12.00 |

### Ancillary Service Cost Centers

| 50.00 | 05000 OPERATING ROOM | 3,379 | 48,916 | 202,867 | 5.00 |
| 51.00 | 05100 ANESTHESIA & OXYGEN | 2,495 | 0 | 0 | 0.00 |

### OUTPATIENT SERVICE COST CENTERS

| 88.00 | 08800 RURAL HEALTH CLINIC | 2,411 | 127 | 1,039,341 | 19.00 |

### Specialty Cost Centers

| 113.00 | 11300 SPECIAL PURPOSE EXPENSE | 113.00 |
| 115.00 | 11500 AMBULATORY SURGICAL CENTER (D.P.) | 0 | 0 | 0 | 0.115.00 |

| 118.00 | 11800 SUBTOTALS (SUM OF LINES 1-117) | 69,100 | 203,674 | 6,532,682 | 127 | -1,795,113 | 118.00 |

### Non-Medical Cost Centers

| 190.00 | 19000 GIFTS, FLOWERS, COFFEE SHOP & CANNED FOOD | 244 | 0 | 0 | 0 | 0.190.00 |
| 190.01 | 19001 OUTPATIENT CLINIC | 2,947 | 2,179 | 4,922 | 5.00 |

| 203.00 | 20300 UNIT COST MULTIPLIER (Wkst. B, Part I) | 4.751899 | 0.952111 | 0.314242 | 4.356,674242 | 203.00 |
| 204.00 | 20400 Cost to be allocated (per Wkst. B, Part I) | 627 | 4,590 | 204.00 |
| 205.00 | 20500 Unit cost multiplier (Wkst. B, Part II) | 0.000096 | 34.772727 | 205.00 |

---

Cost to be allocated (per Wkst. B, Part I)

Provider CCN: 141308

Period: From 05/01/2014 To 04/30/2015

Worksheet B-1

Date/Time Prepared: 9/24/2015 1:35 pm
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### COMPUTATION OF RATIO OF COSTS TO CHARGES

**Title XVIII**

**Hospital**

**Worksheet C**

<table>
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<th>Cost Center Description</th>
<th>Total Cost (from Wkst. B, Part I, col. 26)</th>
<th>Therapy Limit Adj.</th>
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**Subtotal (see instructions)**: 13,652,538

**Less Observation Beds**: 19,255

**Total (see instructions)**: 13,633,283
### Title XVIII

#### Hospital Cost

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<th>Outpatient Charges</th>
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**Note:** All ratios are calculated based on the provided charges and costs.
### Title XVIII: Hospital Cost

**PPS Inpatient Cost Ratio:** 11.00

#### INPATIENT ROUTINE SERVICE COST CENTERS

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<td>46.00 04600 OTHER LONG TERM CARE</td>
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#### ANIMALARY SERVICE COST CENTERS

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#### OUTPATIENT SERVICE COST CENTERS

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#### OTHER REIMBURSABLE COST CENTERS

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#### SPECIAL PURPOSE COST CENTERS

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### Title XIX

#### Hospital

**Worksheet C**

**Part I**

**Date/Time Prepared:** 9/24/2015 1:35 pm

**Provider CCN:** 141308

**Period:**
- From: 05/01/2014
- To: 04/30/2015

#### INPATIENT ROUTINE SERVICE COST CENTERS

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<th>Adj. Total Costs</th>
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#### ANCILLARY SERVICE COST CENTERS

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### Title XIX

#### Hospital

| Period: | | | | | | 
| --- | --- | --- | --- | --- | --- | --- | 
| To | From | 05/01/2014 | 04/30/2015 | | | 

**Worksheet C**

- **Part I**
- **Date/Time Prepared:** 09/24/2015 1:35 pm

**Computations of Ratio of Costs to Charges**

**Provider CCN:** 141308

**Provider Name:** Washington County Hospital

**Cost Center Description**

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**WASHINGTON COUNTY HOSPITAL**

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<td>Cost Reimbursed Services Not Subject To Ded. &amp; Coins. (see inst.)</td>
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## APPOINTMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

**Provider CCN:** 141308  
**Component CCN:** 142308  
**Date/Time Prepared:** 09/24/2015 1:35 pm  
**Worksheet D**  
**Part V**

### Worksheet C, Part I, col. 9

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Cost to Charge Ratio From Worksheet C, Part I, col. 9</th>
<th>PPS Reimbursed Services (see inst.)</th>
<th>Cost Reimbursed Services Subject To Ded. &amp; Coins. (see inst.)</th>
<th>Cost Reimbursed Services Not Subject To Ded. &amp; Coins. (see inst.)</th>
<th>PPS Services (see inst.)</th>
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<td>1.00</td>
<td>2.00</td>
<td>3.00</td>
<td>4.00</td>
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### Ancillary Service Cost Centers

- **50.00 05000 OPERATING ROOM**  
  Cost: 0.360761  
  Charges: 0  
  Costs: 0  
  Subtotal: 0  
  Total: 0  

- **53.00 05300 ANESTHESIA OLOGY**  
  Cost: 2.559769  
  Charges: 0  
  Costs: 0  
  Subtotal: 0  
  Total: 0  

- **54.00 05400 RADIOLOGY- DI AGNOSTI C**  
  Cost: 0.217684  
  Charges: 0  
  Costs: 0  
  Subtotal: 0  
  Total: 0  

- **56.00 06000 LABORATORY**  
  Cost: 0.307793  
  Charges: 0  
  Costs: 0  
  Subtotal: 0  
  Total: 0  

- **65.00 06500 RESPIRATORY THERAPY**  
  Cost: 0.382276  
  Charges: 0  
  Costs: 0  
  Subtotal: 0  
  Total: 0  

- **66.00 06600 PHYSICAL THERAPY**  
  Cost: 0.521515  
  Charges: 0  
  Costs: 0  
  Subtotal: 0  
  Total: 0  

- **67.00 06700 OCCUPATIONAL THERAPY**  
  Cost: 0.000000  
  Charges: 0  
  Costs: 0  
  Subtotal: 0  
  Total: 0  

- **68.00 06800 SPEECH PATHOLOGY**  
  Cost: 0.000000  
  Charges: 0  
  Costs: 0  
  Subtotal: 0  
  Total: 0  

- **68.01 06801 CARDiac REHAB**  
  Cost: 1.087656  
  Charges: 0  
  Costs: 0  
  Subtotal: 0  
  Total: 0  

- **69.00 06900 ELECTROCARDIOLOGY**  
  Cost: 0.064371  
  Charges: 0  
  Costs: 0  
  Subtotal: 0  
  Total: 0  

### Outpatient Service Cost Centers

- **88.00 08800 RURAL HEALTH CLINIC**  
  Cost: 0.000000  
  Charges: 0  
  Costs: 0  
  Subtotal: 0  
  Total: 0  

- **90.00 09000 CLINIC**  
  Cost: 0.000000  
  Charges: 0  
  Costs: 0  
  Subtotal: 0  
  Total: 0  

- **91.00 09100 EMERGENCY**  
  Cost: 0.865782  
  Charges: 0  
  Costs: 0  
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  Total: 0  

### Other Reimbursable Cost Centers

- **95.00 09500 AMBULANCE SERVICES**  
  Cost: 0.000000  
  Charges: 0  
  Costs: 0  
  Subtotal: 0  
  Total: 0  

### Other Reimbursable Cost Centers

- **98.00 09850 OTHER REIMBURSABLE COST CENTERS**  
  Cost: 0.000000  
  Charges: 0  
  Costs: 0  
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### Subtotal (see instructions)

- **200.00**

### Less PBP Clinic Lab. Services-Program Only Charges

- **201.00**

### Net Charges (line 200 +/- line 201)

- **202.00**
### APPOINTMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

#### Title XVIII: Swing Beds - SNF

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Cost Reimbursed Services Subject To Ded. &amp; Coi ns. (see inst.)</th>
<th>Cost Reimbursed Services Not Subject To Ded. &amp; Coi ns. (see inst.)</th>
<th>Cost</th>
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<td>50.00 OPERATING ROOM</td>
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<td>53.00 ANESTHESIOLOGY</td>
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<td>54.00 RADI OLOGY- DIAGNOSTIC C</td>
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<tr>
<td>67.00 OCCUPATIONAL THERAPY</td>
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<tr>
<td>68.00 SPEECH PATHOLOGY</td>
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<td><strong>OUTPATIENT SERVICE COST CENTERS</strong></td>
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<td>88.00 RURAL HEALTH CLINIC</td>
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<td>90.00 CLINIC</td>
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<tr>
<td>91.00 EMERGENCY</td>
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<td>92.00 OBSERVATIONS OF BEDS (NON-DISTINCT PART)</td>
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<td>200.00 Subtotal (see instructions)</td>
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<td>202.00 Net Charges (line 200 +/- line 201)</td>
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## COMPUTATION OF INPATIENT OPERATING COST

### PART I - ALL PROVIDER COMPONENTS

**Inpatient Days**

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<tr>
<th>Cost Center Description</th>
<th>Cost Center Description</th>
<th>Cost Center Description</th>
<th>Cost Center Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)</td>
<td>2.00 Inpatient days (including private room days, excluding swing-bed and newborn days)</td>
<td>3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.</td>
<td>4.00 Semi-private room days (excluding swing-bed and observation bed days)</td>
</tr>
<tr>
<td>5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period</td>
<td>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)</td>
<td>7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period</td>
<td>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)</td>
</tr>
<tr>
<td>9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)</td>
<td>10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)</td>
<td>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)</td>
<td>12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)</td>
</tr>
<tr>
<td>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)</td>
<td>14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)</td>
<td>15.00 Total nursery days (title V or XIX only)</td>
<td>16.00 Nursery days (title V or XIX only)</td>
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<tr>
<td>17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period</td>
<td>18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period</td>
<td>19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period</td>
<td>20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period</td>
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<tr>
<td>21.00 Total general inpatient routine service cost (see instructions)</td>
<td>22.00 Total general inpatient routine service cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)</td>
<td>23.00 Total general inpatient routine service cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)</td>
<td>24.00 Total general inpatient routine service cost applicable to SNF type services through December 31 of the cost reporting period (line 7 x line 19)</td>
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<tr>
<td>25.00 Total general inpatient routine service cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)</td>
<td>26.00 Total swing-bed cost (see instructions)</td>
<td>27.00 Total swing-bed cost (line 21 minus line 26)</td>
<td>28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)</td>
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### MEDICAL NEEDED ROOM DIFFERENTIAL ADJUSTMENT

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<th>Cost Center Description</th>
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<tr>
<td>28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)</td>
<td>29.00 Private room charges (excluding swing-bed charges)</td>
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<tr>
<td>30.00 Semi-private room charges (excluding swing-bed charges)</td>
<td>31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)</td>
</tr>
<tr>
<td>32.00 Average private room per diem charge (line 29 + line 3)</td>
<td>33.00 Average semi-private room per diem charge (line 30 + line 4)</td>
</tr>
<tr>
<td>34.00 Average per diem private room cost differential (line 32 minus line 33)</td>
<td>35.00 Average per diem private room cost differential (line 34 x line 31)</td>
</tr>
<tr>
<td>36.00 Private room cost differential adjustment (line 3 x line 35)</td>
<td>37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)</td>
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### SWING-BED ADJUSTMENT

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<th>Cost Center Description</th>
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<tr>
<td>38.00 Adjusted general inpatient routine service per diem (see instructions)</td>
<td>39.00 Program general inpatient routine service cost (line 9 x line 38)</td>
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<tr>
<td>40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)</td>
<td>41.00 Total Program general inpatient routine service cost (line 39 + line 40)</td>
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**Title XVIII Hospital**

Worksheet D-1  
Provider CCN: 141308  
Period: From 05/01/2014 To 04/30/2015  
Date/Time Prepared: 9/24/2015 1:35 pm  
Provider CCN: 141308  
Program general inpatient routine service cost (line 9 x line 38)  
Total Program general inpatient routine service cost (line 39 + line 40)  
MCRI F32 - 7.7.157.3
<table>
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<th>Cost Center Description</th>
<th>Total Inpatient Cost</th>
<th>Total Inpatient Days</th>
<th>Average Per Day (col. 2)</th>
<th>Program Days</th>
<th>Program Cost (col. 3 x col. 4)</th>
<th>Cost Center Description</th>
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| **Target Amount and Lim it Computation** | 54.00 | | | | | |
| **Program Discharges** | 55.00 | | | | | |
| **Target amount per discharge** | 55.00 | | | | | |
| **Total program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs** | 53.00 | | | | | |

| **Program Inpatient Routine Sw ing 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 | | | | | |
| **Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(CAH see instructions)** | 363,850 | | | | | |
| **Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)** | 1,178,529 | | | | | |
| **Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)** | 67.00 | | | | | |
| **Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)** | 68.00 | | | | | |

| **PART IV - Computation of Observation Bed Pass Through Cost** | 87.00 | | | | | |
| **Total observation bed days (see instructions)** | 29 | | | | | |
| **Adjusted general inpatient routine cost per diem(line 27 + line 2)** | 663.96 | | | | | |
| **Observation bed cost (line 87 x line 88)(see instructions)** | 19,255 | | | | | |
### COMPUTATION OF INPATIENT OPERATING COST

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Cost</th>
<th>Routine Cost (from line 27)</th>
<th>column 1 ÷ column 2</th>
<th>Total Observation Bed Cost (from line 89)</th>
<th>Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>90.00</strong> Capital-related cost</td>
<td>63,703</td>
<td>207,821</td>
<td>0.306528</td>
<td>19,255</td>
<td>5,902</td>
</tr>
<tr>
<td><strong>91.00</strong> Nursing School cost</td>
<td>0</td>
<td>207,821</td>
<td>0.000000</td>
<td>19,255</td>
<td>0</td>
</tr>
<tr>
<td><strong>92.00</strong> Allied health cost</td>
<td>0</td>
<td>207,821</td>
<td>0.000000</td>
<td>19,255</td>
<td>0</td>
</tr>
<tr>
<td><strong>93.00</strong> All other Medical Education</td>
<td>0</td>
<td>207,821</td>
<td>0.000000</td>
<td>19,255</td>
<td>0</td>
</tr>
</tbody>
</table>

### COMPUTATION OF OBSERVATION BED PASS THROUGH COST

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Cost</th>
<th>Routine Cost</th>
<th>column 1 ÷ column 2</th>
<th>Total Observation Bed Cost</th>
<th>Observation Bed Pass Through Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>Capital-related cost</td>
<td>63,703</td>
<td>207,821</td>
<td>0.306528</td>
<td>19,255</td>
<td>5,902</td>
</tr>
<tr>
<td>91</td>
<td>Nursing School cost</td>
<td>0</td>
<td>207,821</td>
<td>0.000000</td>
<td>19,255</td>
<td>0</td>
</tr>
<tr>
<td>92</td>
<td>Allied health cost</td>
<td>0</td>
<td>207,821</td>
<td>0.000000</td>
<td>19,255</td>
<td>0</td>
</tr>
<tr>
<td>93</td>
<td>All other Medical Education</td>
<td>0</td>
<td>207,821</td>
<td>0.000000</td>
<td>19,255</td>
<td>0</td>
</tr>
</tbody>
</table>
### INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

<table>
<thead>
<tr>
<th>Provider CCN: 141308</th>
<th>Date/Time Prepared: 9/24/2015 1:35 pm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worksheet D-3</td>
<td>Worksheet D-3</td>
</tr>
</tbody>
</table>

#### Title XVII

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Ratio of Cost To Charges</th>
<th>Inpatient Program Charges</th>
<th>Inpatient Program Costs (col. 1 x col. 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.00 Adults &amp; Pediatrics</td>
<td>1.00</td>
<td>2.00</td>
<td>3.00</td>
</tr>
</tbody>
</table>

#### INPATIENT ROUTINE SERVICE COST CENTERS

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Ratio of Cost To Charges</th>
<th>Inpatient Program Charges</th>
<th>Inpatient Program Costs (col. 1 x col. 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>50.00 Operating Room</td>
<td>0.360761</td>
<td>1,764</td>
<td>636</td>
</tr>
<tr>
<td>53.00 Anesthesia</td>
<td>2.559769</td>
<td>950</td>
<td>2,432</td>
</tr>
<tr>
<td>54.00 Radiology</td>
<td>0.217684</td>
<td>44,573</td>
<td>9,703</td>
</tr>
<tr>
<td>60.00 Laboratory</td>
<td>0.307793</td>
<td>62,849</td>
<td>19,344</td>
</tr>
<tr>
<td>65.00 Respiratory Therapy</td>
<td>0.382276</td>
<td>46,902</td>
<td>17,930</td>
</tr>
<tr>
<td>66.00 Physical Therapy</td>
<td>0.521515</td>
<td>16,383</td>
<td>8,544</td>
</tr>
<tr>
<td>67.00 Occupational Therapy</td>
<td>0.000000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>68.00 Speech Pathology</td>
<td>0.000000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>69.00 Cardiac Rehab</td>
<td>1.087656</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>71.00 Medical SUPPlIES CHARGED TO PATIENTS</td>
<td>0.945494</td>
<td>2,703</td>
<td>2,556</td>
</tr>
<tr>
<td>72.00 Implant Dev. CHARGED TO PATIENTS</td>
<td>0.854150</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>73.00 Drugs CHARGED TO PATIENTS</td>
<td>0.410409</td>
<td>74,052</td>
<td>30,664</td>
</tr>
<tr>
<td>76.00 Oncology</td>
<td>0.310034</td>
<td>0</td>
<td>0</td>
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</table>

#### OUTPATIENT SERVICE COST CENTERS

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Ratio of Cost To Charges</th>
<th>Inpatient Program Charges</th>
<th>Inpatient Program Costs (col. 1 x col. 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>88.00 Rural Health Clinic</td>
<td>0.000000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>90.00 Clinic</td>
<td>0.000000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>91.00 Emergency</td>
<td>1.187695</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>92.00 Observation Beds (Non-DISTINCT PART)</td>
<td>0.865782</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>93.00 Other Outpatient Service Cost Centers</td>
<td>0.086824</td>
<td>5,497</td>
<td>477</td>
</tr>
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</table>

#### OTHER REIMBURSABLE COST CENTERS

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Ratio of Cost To Charges</th>
<th>Inpatient Program Charges</th>
<th>Inpatient Program Costs (col. 1 x col. 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>95.00 Ambulance Services</td>
<td>0.000000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>98.00 Other Reimbursement Costs Centers</td>
<td>0.000000</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

#### Total Charges (sum of lines 50-94 and 96-98)

- Total: 258,268
- Reimbursement: 258,268
- Net: 0

**Note:** Charges are from 05/01/2014 to 04/30/2015.
<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Ratio of Cost To Charges</th>
<th>Inpatient Program Charges</th>
<th>Inpatient Program Costs (col. 1 x col. 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>2.00</td>
<td>3.00</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Ratio of Cost To Charges</th>
<th>Inpatient Program Charges</th>
<th>Inpatient Program Costs (col. 1 x col. 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPERATING ROOM</td>
<td>0.360761</td>
<td>1,487</td>
<td>536</td>
</tr>
<tr>
<td>ANESTHESIology</td>
<td>2.559769</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RADIology - Diagnostic</td>
<td>0.217684</td>
<td>49,487</td>
<td>10,773</td>
</tr>
<tr>
<td>LABORATORY</td>
<td>0.307793</td>
<td>106,021</td>
<td>32,633</td>
</tr>
<tr>
<td>RESPIRATORY THERAPY</td>
<td>0.382276</td>
<td>126,557</td>
<td>48,380</td>
</tr>
<tr>
<td>PHYSICAL THERAPY</td>
<td>0.521515</td>
<td>506,849</td>
<td>264,329</td>
</tr>
<tr>
<td>OCCUPATIONAL THERAPY</td>
<td>0.000000</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SPEECH PATHOLOGY</td>
<td>0.000000</td>
<td>0</td>
<td>0</td>
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<tr>
<td>CARDCARE REHAB</td>
<td>1.087656</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ELECTROCARDIOLOGY</td>
<td>0.064371</td>
<td>692</td>
<td>45</td>
</tr>
<tr>
<td>MEDICAL SUPPLIES CHARGED TO PATIENTS</td>
<td>0.945494</td>
<td>7,808</td>
<td>7,382</td>
</tr>
<tr>
<td>IMPLANT DEVELOPMENT CHARGED TO PATIENTS</td>
<td>0.854150</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DRUGS CHARGED TO PATIENTS</td>
<td>0.410899</td>
<td>395,769</td>
<td>163,864</td>
</tr>
<tr>
<td>MEDICAL SUPPLIES CHARGED TO PATIENTS</td>
<td>0.310034</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RURAL HEALTH CLINIC</td>
<td>0.000000</td>
<td>0</td>
<td>88</td>
</tr>
<tr>
<td>CLINIC</td>
<td>0.000000</td>
<td>0</td>
<td>90</td>
</tr>
<tr>
<td>EMERGENCY</td>
<td>1.187695</td>
<td>0</td>
<td>91</td>
</tr>
<tr>
<td>OBSERVATORY ON BEDS (NON-STD NCT PART)</td>
<td>0.865782</td>
<td>0</td>
<td>92</td>
</tr>
<tr>
<td>OTHER OUTPATIENT ENTRAINED SERVICE COST CENTER</td>
<td>0.086824</td>
<td>6,707</td>
<td>509</td>
</tr>
<tr>
<td>AMBULANCE SERVICES</td>
<td>0.000000</td>
<td>0</td>
<td>95</td>
</tr>
<tr>
<td>OTHER REIMBURSABLE COST CENTERS</td>
<td>0.000000</td>
<td>0</td>
<td>98</td>
</tr>
<tr>
<td>Total (sum of lines 50-94 and 96-98)</td>
<td>1,201,377</td>
<td>528,544</td>
<td>202,000</td>
</tr>
<tr>
<td>Net Charges (line 200 minus line 201)</td>
<td>1,201,377</td>
<td>528,544</td>
<td>202,000</td>
</tr>
</tbody>
</table>
### CALCULATION OF REIMBURSEMENT SETTLEMENT

<table>
<thead>
<tr>
<th>PART B - MEDICAL AND OTHER HEALTH SERVICES</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00 Medical and other services (see instructions)</td>
<td>3,025,454</td>
</tr>
<tr>
<td>2.00 Medical and other services reimbursed under OPPS (see instructions)</td>
<td>0</td>
</tr>
<tr>
<td>3.00 PPS payments</td>
<td>0</td>
</tr>
<tr>
<td>4.00 Outlier payment (see instructions)</td>
<td>0</td>
</tr>
<tr>
<td>5.00 Enter the hospital specific payment to cost ratio (see instructions)</td>
<td>0.000</td>
</tr>
<tr>
<td>6.00 Line 2 times line 5</td>
<td>0</td>
</tr>
<tr>
<td>7.00 Sum of line 3 plus line 4 divided by line 6</td>
<td>0.00</td>
</tr>
<tr>
<td>8.00 Transitional corridor payment (see instructions)</td>
<td>0</td>
</tr>
<tr>
<td>9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200</td>
<td>0</td>
</tr>
<tr>
<td>10.00 Organ acquisitions</td>
<td>0</td>
</tr>
<tr>
<td>11.00 Total cost (sum of lines 1 and 10) (see instructions)</td>
<td>3,025,454</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PART C - MEDICAL AND OTHER HEALTH SERVICES</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.00 Ancillary service charges</td>
<td>0</td>
</tr>
<tr>
<td>13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)</td>
<td>0</td>
</tr>
<tr>
<td>14.00 Total reasonable charges (sum of lines 12 and 13)</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CUSTOMARY CHARGES</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis</td>
<td>0</td>
</tr>
<tr>
<td>16.00 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)</td>
<td>0</td>
</tr>
<tr>
<td>17.00 Ratio of line 15 to line 16 (not to exceed 1.000000)</td>
<td>0.000000</td>
</tr>
<tr>
<td>18.00 Total customary charges (see instructions)</td>
<td>0</td>
</tr>
<tr>
<td>19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)</td>
<td>0</td>
</tr>
<tr>
<td>20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)</td>
<td>0</td>
</tr>
<tr>
<td>21.00 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)</td>
<td>3,055,709</td>
</tr>
<tr>
<td>22.00 Interns and residents (see instructions)</td>
<td>0</td>
</tr>
<tr>
<td>23.00 Cost of physicians' services in a teaching hospital (see instructions)</td>
<td>0</td>
</tr>
<tr>
<td>24.00 Total prospective payment (sum of lines 3, 4, 8 and 9)</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV CES)</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>33.00 Composite rate ESRD (from Wkst. E-4, line 51)</td>
<td>0</td>
</tr>
<tr>
<td>34.00 Allowable bad debts (see instructions)</td>
<td>85,480</td>
</tr>
<tr>
<td>35.00 Adjusted reimbursable bad debts (see instructions)</td>
<td>64,965</td>
</tr>
<tr>
<td>36.00 Allowable bad debts for dual eligible beneficiarries (see instructions)</td>
<td>85,480</td>
</tr>
<tr>
<td>37.00 Subtotal (see instructions)</td>
<td>1,928,683</td>
</tr>
<tr>
<td>38.00 Medicare - LCC reconciliation amount from PS&amp;R</td>
<td>0</td>
</tr>
<tr>
<td>39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</td>
<td>0</td>
</tr>
<tr>
<td>40.00 Recovery of accelerated depreciation</td>
<td>0</td>
</tr>
<tr>
<td>41.00 Interim payments</td>
<td>1,940,928</td>
</tr>
<tr>
<td>42.00 Tentative settlement (for contractors use only)</td>
<td>0</td>
</tr>
<tr>
<td>43.00 Balance due provider/program (see instructions)</td>
<td>-50,819</td>
</tr>
<tr>
<td>44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TO BE COMPLETED BY CONTRACTOR</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>90.00 Original outlier amount (see instructions)</td>
<td>0</td>
</tr>
<tr>
<td>91.00 Outlier reconciliation adjustment amount (see instructions)</td>
<td>0</td>
</tr>
<tr>
<td>92.00 The rate used to calculate the Time Value of Money</td>
<td>0.00</td>
</tr>
<tr>
<td>93.00 Time Value of Money (see instructions)</td>
<td>93.00</td>
</tr>
<tr>
<td>94.00 Total (sum of lines 91 and 93)</td>
<td>94.00</td>
</tr>
<tr>
<td>Part</td>
<td>Inpatient</td>
</tr>
<tr>
<td>------</td>
<td>------------</td>
</tr>
<tr>
<td>1.00</td>
<td>Total interim payments paid to provider</td>
</tr>
<tr>
<td>2.00</td>
<td>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 &quot;NONE&quot; or enter a zero</td>
</tr>
<tr>
<td>3.00</td>
<td>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 &quot;NONE&quot; or enter a zero.</td>
</tr>
</tbody>
</table>

**Program to Provider**

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2015</td>
<td>7,632</td>
</tr>
<tr>
<td>04/30/2015</td>
<td>95,258</td>
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</tbody>
</table>

**Provider to Program**

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/30/2015</td>
<td>18,160</td>
</tr>
<tr>
<td>04/30/2015</td>
<td>256,192</td>
</tr>
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</table>

**Program to Provider**

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2015</td>
<td>18,442</td>
</tr>
</tbody>
</table>

**Provider to Program**

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2015</td>
<td>5,240</td>
</tr>
</tbody>
</table>

**Settlement to Provider**

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>5,240</td>
</tr>
</tbody>
</table>

**Settlement to Program**

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>50,819</td>
</tr>
</tbody>
</table>

**Total Medicare program liability (see instructions)**

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,890,109</td>
</tr>
</tbody>
</table>

**Contractor**

<table>
<thead>
<tr>
<th>Name of Contractor</th>
<th>Contractor Number</th>
<th>NPR Date (Mo/Day/Yr)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>Inpatient Part A</td>
<td>Part B</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------</td>
<td>--------</td>
</tr>
<tr>
<td></td>
<td>mm/dd/yyyy</td>
<td>Amount</td>
</tr>
<tr>
<td>1.00 Total interim payments paid to provider</td>
<td>1,710,864</td>
<td>0</td>
</tr>
<tr>
<td>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 &quot;NONE&quot; or enter a zero</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>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 &quot;NONE&quot; or enter a zero. (1)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Program to Provider**

<table>
<thead>
<tr>
<th></th>
<th>01/01/2015</th>
<th>29,289</th>
<th>0</th>
<th>3.01</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.02</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3.02</td>
</tr>
<tr>
<td>3.03</td>
<td>0</td>
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<tr>
<td>3.04</td>
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<td>3.04</td>
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<td>3.05</td>
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**Provider to Program**

<table>
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<tr>
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<th>04/30/2015</th>
<th>134,603</th>
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<th>3.50</th>
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<tbody>
<tr>
<td>3.52</td>
<td>0</td>
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<tr>
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<tr>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>3.54</td>
</tr>
<tr>
<td>3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)</td>
<td>-105,314</td>
<td>0</td>
<td>3.99</td>
<td></td>
</tr>
<tr>
<td>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)</td>
<td>1,605,550</td>
<td>0</td>
<td>4.00</td>
<td></td>
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</table>

**To Be Completed By Contractor**

<table>
<thead>
<tr>
<th></th>
<th>5.00</th>
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<tbody>
<tr>
<td>5.01 TENTATIVE TO PROVIDER</td>
<td>0</td>
</tr>
<tr>
<td>5.02 TENTATIVE TO PROGRAM</td>
<td>0</td>
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<tr>
<td>5.03 TENTATIVE TO PROGRAM</td>
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**Program to Provider**

<table>
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<tr>
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<tr>
<td>5.51 TENTATIVE TO PROGRAM</td>
<td>0</td>
</tr>
<tr>
<td>5.52 TENTATIVE TO PROGRAM</td>
<td>0</td>
</tr>
<tr>
<td>5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)</td>
<td>0</td>
</tr>
<tr>
<td>6.00 Determined net settlement amount (balance due) based on the cost report. (1)</td>
<td>5,785</td>
</tr>
<tr>
<td>6.01 SETTLEMENT TO PROVIDER</td>
<td>0</td>
</tr>
<tr>
<td>6.02 SETTLEMENT TO PROGRAM</td>
<td>0</td>
</tr>
<tr>
<td>7.00 Total Medicare program liability (see instructions)</td>
<td>1,611,335</td>
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**Contractor Number**

<table>
<thead>
<tr>
<th>Contractor Number</th>
<th>NPR Date (Mo/Day/Yr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1.00</td>
</tr>
<tr>
<td></td>
<td>2.00</td>
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</table>

8.00 Name of Contractor
### Title XVIII: Hospital Cost

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Value</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I, col. 15 line 14</td>
<td>93</td>
<td>1.00</td>
</tr>
<tr>
<td>2.00</td>
<td>Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12</td>
<td>215</td>
<td>2.00</td>
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<tr>
<td>3.00</td>
<td>Medicare HMO days from Wkst. S-3, Pt. I, col. 6 line 2</td>
<td>0</td>
<td>3.00</td>
</tr>
<tr>
<td>4.00</td>
<td>Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12</td>
<td>284</td>
<td>4.00</td>
</tr>
<tr>
<td>5.00</td>
<td>Total hospital charges from Wkst. C, Pt. I, col. 8 line 200</td>
<td>23,344,675</td>
<td>5.00</td>
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<tr>
<td>6.00</td>
<td>Total hospital charity care charges from Wkst. S-10, col. 3 line 20</td>
<td>126,459</td>
<td>6.00</td>
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<tr>
<td>7.00</td>
<td>CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168</td>
<td>65,171</td>
<td>7.00</td>
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<tr>
<td>8.00</td>
<td>Calculation of the HIT incentive payment (see instructions)</td>
<td>62,642</td>
<td>8.00</td>
</tr>
<tr>
<td>9.00</td>
<td>Sequestration adjustment amount (see instructions)</td>
<td>1,253</td>
<td>9.00</td>
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<tr>
<td>10.00</td>
<td>Calculation of the HIT incentive payment after sequestration (see instructions)</td>
<td>61,389</td>
<td>10.00</td>
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### INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

<table>
<thead>
<tr>
<th>Line</th>
<th>Description</th>
<th>Value</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.00</td>
<td>Initial/interim HIT payment adjustment (see instructions)</td>
<td>59,518</td>
<td>30.00</td>
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<tr>
<td>31.00</td>
<td>Other Adjustment (specify)</td>
<td>0</td>
<td>31.00</td>
</tr>
<tr>
<td>32.00</td>
<td>Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)</td>
<td>1,871</td>
<td>32.00</td>
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<tr>
<td>Title XVII</td>
<td>Swing Beds - SNF</td>
<td>Part A</td>
<td>Part B</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>1.00</td>
<td>Inpatient routine services - swing bed-SNF (see instructions)</td>
<td>1,190,314</td>
<td>0</td>
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<tr>
<td>2.00</td>
<td>Inpatient routine services - swing bed-NF (see instructions)</td>
<td>533,829</td>
<td>0</td>
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<tr>
<td>3.00</td>
<td>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)</td>
<td>1,724,143</td>
<td>0</td>
</tr>
<tr>
<td>4.00</td>
<td>Per diem cost for interns and residents not in approved teaching program (see instructions)</td>
<td>0</td>
<td>4.00</td>
</tr>
<tr>
<td>5.00</td>
<td>Program days</td>
<td>0</td>
<td>5.00</td>
</tr>
<tr>
<td>6.00</td>
<td>Interns and residents not in approved teaching program (see instructions)</td>
<td>0</td>
<td>6.00</td>
</tr>
<tr>
<td>7.00</td>
<td>Utilization review - physician compensation - SNF optional method only</td>
<td>0</td>
<td>7.00</td>
</tr>
<tr>
<td>8.00</td>
<td>Subtotal (sum of lines 1 through 3 plus lines 6 and 7)</td>
<td>1,724,143</td>
<td>0</td>
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<tr>
<td>9.00</td>
<td>Primary payer payments (see instructions)</td>
<td>0</td>
<td>9.00</td>
</tr>
<tr>
<td>10.00</td>
<td>Subtotal (line 8 minus line 9)</td>
<td>1,724,143</td>
<td>0</td>
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<tr>
<td>11.00</td>
<td>Deductibles billed to program patients (exclude amounts applicable to physician professional services)</td>
<td>0</td>
<td>11.00</td>
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<tr>
<td>12.00</td>
<td>Subtotal (line 10 minus line 11)</td>
<td>1,724,143</td>
<td>0</td>
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<tr>
<td>13.00</td>
<td>Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)</td>
<td>79,924</td>
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<tr>
<td>14.00</td>
<td>80% of Part B costs (line 12 x 80%)</td>
<td>1,403,880</td>
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<tr>
<td>15.00</td>
<td>Subtotal (enter the lesser of line 12 minus line 13, or line 14)</td>
<td>1,644,219</td>
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<tr>
<td>16.00</td>
<td>Other adjustments (see instructions) (specify)</td>
<td>0</td>
<td>16.50</td>
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<tr>
<td>16.50</td>
<td>Pioneer ACO demonstration payment adjustment (see instructions)</td>
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<td>16.55</td>
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<td>17.00</td>
<td>Allowable bad debts (see instructions)</td>
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<tr>
<td>17.01</td>
<td>Adjusted reimbursable bad debts (see instructions)</td>
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<tr>
<td>18.00</td>
<td>Allowable bad debts for dual eligible beneficiaries (see instructions)</td>
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<td>18.00</td>
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<tr>
<td>19.00</td>
<td>Total (see instructions)</td>
<td>1,644,219</td>
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<tr>
<td>19.01</td>
<td>Sequestration adjustment (see instructions)</td>
<td>32,884</td>
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<tr>
<td>20.00</td>
<td>Interim payments</td>
<td>1,605,550</td>
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<tr>
<td>21.00</td>
<td>Tentative settlement (for contractor use only)</td>
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<tr>
<td>22.00</td>
<td>Balance due provider/program (line 19 minus lines 19.01, 20, and 21)</td>
<td>5,785</td>
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<tr>
<td>23.00</td>
<td>Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2</td>
<td>0</td>
<td>23.00</td>
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<tr>
<td>Title XVIII</td>
<td>Hospital</td>
<td>Cost</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>----------</td>
<td>------</td>
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</tr>
<tr>
<td>1.00</td>
<td>Inpatient services</td>
<td>235,204</td>
<td>1.00</td>
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<tr>
<td>2.00</td>
<td>Nursing and Allied Health Managed Care payment [see instructions]</td>
<td>0</td>
<td>2.00</td>
</tr>
<tr>
<td>3.00</td>
<td>Organ acquisition</td>
<td>0</td>
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<tr>
<td>4.00</td>
<td>Subtotal (sum of lines 1 through 3)</td>
<td>235,204</td>
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<tr>
<td>5.00</td>
<td>Primary payer payments</td>
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<tr>
<td>6.00</td>
<td>Total cost (line 4 less line 5). For CAH [see instructions]</td>
<td>237,556</td>
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<td>9.00</td>
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<table>
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<td>15.00</td>
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<table>
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<th>COMPUTATION OF REIMBURSEMENT SETTLEMENT</th>
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<td>19.00</td>
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<td>34.00</td>
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**BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)**

<table>
<thead>
<tr>
<th>General Fund</th>
<th>Specific Purpose Fund</th>
<th>Endowment Fund</th>
<th>Plant Fund</th>
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<td>1.00</td>
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### CURRENT ASSETS

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<tr>
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<th>3.00</th>
<th>4.00</th>
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<tbody>
<tr>
<td>Cash on hand in banks</td>
<td>1,494,833</td>
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<tr>
<td>Temporary investments</td>
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<td>0</td>
</tr>
<tr>
<td>Notes receivable</td>
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</tr>
<tr>
<td>Accounts receivable</td>
<td>2,365,314</td>
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<td>0</td>
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<tr>
<td>Other receivable</td>
<td>43,574</td>
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<tr>
<td>Allowances for uncollectible notes and accounts receivable</td>
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<tr>
<td>Inventory</td>
<td>324,424</td>
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<tr>
<td>Prepaid expenses</td>
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<tr>
<td>Other current assets</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Due from other funds</td>
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<tr>
<td>Total current assets (sum of lines 1-10)</td>
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### FIXED ASSETS

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<td>Land</td>
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<tr>
<td>Buildings</td>
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<tr>
<td>Accumulated depreciation</td>
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<tr>
<td>Buildings</td>
<td>9,435,837</td>
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<tr>
<td>Accumulated depreciation</td>
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<tr>
<td>Leasehold improvements</td>
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<td>0</td>
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<td>0</td>
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<tr>
<td>Accumulated depreciation</td>
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<td>0</td>
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<tr>
<td>Accumulated depreciation</td>
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<td>0</td>
</tr>
<tr>
<td>M nor equi pmnt depreciable</td>
<td>0</td>
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</tr>
<tr>
<td>M nor equi pmnt depreciable</td>
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<tr>
<td>M nor equi pmnt depreciable</td>
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<td>0</td>
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<tr>
<td>M nor equi pmnt depreciable</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Total fixed assets (sum of lines 12-29)</td>
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### OTHER ASSETS

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<tr>
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<th>2.00</th>
<th>3.00</th>
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<tr>
<td>Deposits on leases</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Due from owners/officers</td>
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<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other assets</td>
<td>0</td>
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<td>Total other assets (sum of lines 31-34)</td>
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<tr>
<td>Total assets (sum of lines 11, 30, and 35)</td>
<td>8,578,041</td>
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### CURRENT LIABILITIES

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<tr>
<td>Accounts payable</td>
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<td>Salaries, wages, and fees payable</td>
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<td>Payroll taxes payable</td>
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<td>Notes and loans payable (short term)</td>
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<td>Deferred income</td>
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<td>Accelerated payments</td>
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<td>Due to other funds</td>
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<td>Other current liabilities</td>
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### LONG TERM LIABILITIES

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<tr>
<td>Mortgage payable</td>
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<td>Notes payable</td>
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<td>Unsecured loans</td>
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<td>Other long term liabilities</td>
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<td>Total long term liabilities (sum of lines 46 thru 49)</td>
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<td>Total liabilities (sum of lines 45 and 50)</td>
<td>3,572,776</td>
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### CAPITAL ACCOUNTS

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</thead>
<tbody>
<tr>
<td>General fund balance</td>
<td>5,005,265</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Specific purpose fund</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>Donor created - endowment fund balance - restricted</td>
<td>0</td>
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<td>Donor created - endowment fund balance - unrestricted</td>
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<td>Governing body created - endowment fund balance</td>
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<tr>
<td>Plant fund balance - invested in plant</td>
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<tr>
<td>Plant fund balance - reserve for plant improvement, replacement, and expansion</td>
<td>0</td>
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<tr>
<td>Total fund balances (sum of lines 52 thru 58)</td>
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<td>Total liabilities and fund balances (sum of lines 51 and 39)</td>
<td>8,578,041</td>
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# Statement of Changes in Fund Balances

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<th>Period:</th>
<th>To 04/30/2015</th>
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</thead>
</table>

## General Fund

<table>
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<tr>
<th>Line</th>
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<th>2.00</th>
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<th>4.00</th>
<th>5.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>Fund balances at beginning of period</td>
<td>5,032,315</td>
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<td>0</td>
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<td>1.00</td>
</tr>
<tr>
<td>2.00</td>
<td>Net income (loss) (from Wkst. G-3, line 29)</td>
<td>-27,050</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2.00</td>
</tr>
<tr>
<td>3.00</td>
<td>Total (sum of line 1 and line 2)</td>
<td>5,005,265</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3.00</td>
</tr>
<tr>
<td>4.00</td>
<td>Additions (credit adjustments) (specify)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4.00</td>
</tr>
<tr>
<td>5.00</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5.00</td>
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<tr>
<td>6.00</td>
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<tr>
<td>7.00</td>
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<td>0</td>
<td>9.00</td>
</tr>
<tr>
<td>10.00</td>
<td>Total additions (sum of line 4-9)</td>
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<td>0</td>
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<td>0</td>
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</tr>
<tr>
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<td>Subtotal (line 3 plus line 10)</td>
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<tr>
<td>12.00</td>
<td>Deductions (debit adjustments) (specify)</td>
<td>0</td>
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<td>12.00</td>
</tr>
<tr>
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<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>18.00</td>
<td>Total deductions (sum of lines 12-17)</td>
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<td>0</td>
<td>18.00</td>
</tr>
<tr>
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<td>Fund balance at end of period per balance sheet (line 11 minus line 18)</td>
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## Special Purpose Fund

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<th>4.00</th>
<th>5.00</th>
</tr>
</thead>
<tbody>
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<td>Fund balances at beginning of period</td>
<td>0</td>
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<td>0</td>
<td>0</td>
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<td>2.00</td>
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<tr>
<td>3.00</td>
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<td>0</td>
<td>0</td>
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<tr>
<td>4.00</td>
<td>Additions (credit adjustments) (specify)</td>
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<tr>
<td>10.00</td>
<td>Total additions (sum of line 4-9)</td>
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<tr>
<td>12.00</td>
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<tr>
<td>18.00</td>
<td>Total deductions (sum of lines 12-17)</td>
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<td>0</td>
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## Endowment Fund

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<tbody>
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<td>1.00</td>
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<td>2.00</td>
<td>Net income (loss) (from Wkst. G-3, line 29)</td>
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<tr>
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<td>Total additions (sum of line 4-9)</td>
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<tr>
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<td>0</td>
<td>0</td>
<td>17.00</td>
</tr>
<tr>
<td>18.00</td>
<td>Total deductions (sum of lines 12-17)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>18.00</td>
</tr>
<tr>
<td>19.00</td>
<td>Fund balance at end of period per balance sheet (line 11 minus line 18)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>19.00</td>
</tr>
</tbody>
</table>
## STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

### Provider CCN: 141308

**Period:**
- **From:** 05/01/2014
- **To:** 04/30/2015

**Date/Time Prepared:** 9/24/2015 1:35 pm

### Worksheet G-2

#### Parts I & II

<table>
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<th>Cost Center Description</th>
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<th>Outpatient</th>
<th>Total</th>
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<td>1.00 Hospital</td>
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<td>248,487</td>
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<td>2.00 SUBPROVI DER - IPF</td>
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<td>2.00</td>
</tr>
<tr>
<td>3.00 SUBPROVI DER - IRF</td>
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<td></td>
<td>3.00</td>
</tr>
<tr>
<td>4.00 SUBPROVI DER</td>
<td></td>
<td></td>
<td>4.00</td>
</tr>
<tr>
<td>5.00 Swng bed - SNF</td>
<td>529,620</td>
<td>529,620</td>
<td>5.00</td>
</tr>
<tr>
<td>6.00 Swng bed - NF</td>
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<td>0</td>
<td>6.00</td>
</tr>
<tr>
<td>7.00 SKI LLED NURSI NG FACILIT Y</td>
<td></td>
<td></td>
<td>7.00</td>
</tr>
<tr>
<td>8.00 NURSI NG FACILIT Y</td>
<td></td>
<td></td>
<td>8.00</td>
</tr>
<tr>
<td>9.00 OTHER LONG TERM CARE</td>
<td>1,208,648</td>
<td>1,208,648</td>
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</tr>
<tr>
<td>10.00 Total general inpatient care services (sum of lines 1-9)</td>
<td>1,986,755</td>
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</tbody>
</table>

#### Intensive Care Type Inpatient Hospital Services

<table>
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<th>Total</th>
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<td>11.00</td>
</tr>
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<td>12.00 CORONARY CARE UNI T</td>
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<tr>
<td>13.00 BURN INTENSIVE CARE UNI T</td>
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<td>14.00 SURGI CAL INTENSIVE CARE UNI T</td>
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<tr>
<td>15.00 OTHER SPEC AL CARE (SPEC FY)</td>
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<tr>
<td>16.00 Total intensive care type inpatient hospital services (sum of lines 11-15)</td>
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<tr>
<td>17.00 Total inpatient routine care services (sum of lines 10 and 16)</td>
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<td>1,986,755</td>
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<tr>
<td>18.00 Ancillary services</td>
<td>1,701,673</td>
<td>19,551,427</td>
<td>21,253,093</td>
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<td>19.00 Outpatient services</td>
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<td>21,253,093</td>
<td>21,627,803</td>
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<tr>
<td>20.00 RURAL HEALTH CLINIC</td>
<td>1,314,753</td>
<td>1,314,753</td>
<td>20.00</td>
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<tr>
<td>21.00 FEDERALLY QUALIFIED HEALTH CENTER</td>
<td>0</td>
<td>0</td>
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<tr>
<td>22.00 HEALTH AGENCY</td>
<td></td>
<td></td>
<td>22.00</td>
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<tr>
<td>23.00 AMBULANCE SERVICES</td>
<td>0</td>
<td>0</td>
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<tr>
<td>24.00 CMHC</td>
<td></td>
<td></td>
<td>24.00</td>
</tr>
<tr>
<td>25.00 AMBULATORY SURGICAL CENTER (D.P.)</td>
<td>0</td>
<td>0</td>
<td>25.00</td>
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<tr>
<td>26.00 HOSPICE</td>
<td>26.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>27.00 CHART CARE</td>
<td>0</td>
<td>0</td>
<td>27.00</td>
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<tr>
<td>28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)</td>
<td>3,688,428</td>
<td>21,240,893</td>
<td>24,929,319</td>
</tr>
</tbody>
</table>

### Part II - OPERATING EXPENSES

<table>
<thead>
<tr>
<th>Cost Center Description</th>
<th>Inpatient</th>
<th>Outpatient</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>29.00 Operating expenses (per Wkst. A, column 3, line 200)</td>
<td>14,394,399</td>
<td></td>
<td>29.00</td>
</tr>
<tr>
<td>30.00 ADD (SPEC FY)</td>
<td>0</td>
<td></td>
<td>30.00</td>
</tr>
<tr>
<td>31.00</td>
<td>0</td>
<td></td>
<td>31.00</td>
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<td>32.00</td>
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<td>33.00</td>
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<td>33.00</td>
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<td>34.00</td>
<td></td>
<td></td>
<td>34.00</td>
</tr>
<tr>
<td>35.00</td>
<td></td>
<td></td>
<td>35.00</td>
</tr>
<tr>
<td>36.00 Total additions (sum of lines 30-35)</td>
<td>0</td>
<td></td>
<td>36.00</td>
</tr>
<tr>
<td>37.00 DEDUCT (SPEC FY)</td>
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<td></td>
<td>37.00</td>
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<td>38.00</td>
<td>0</td>
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<td>39.00</td>
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</tr>
<tr>
<td>40.00</td>
<td>0</td>
<td></td>
<td>40.00</td>
</tr>
<tr>
<td>41.00</td>
<td>0</td>
<td></td>
<td>41.00</td>
</tr>
<tr>
<td>42.00 Total deductions (sum of lines 37-41)</td>
<td>0</td>
<td></td>
<td>42.00</td>
</tr>
<tr>
<td>43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)</td>
<td>14,394,399</td>
<td></td>
<td>43.00</td>
</tr>
</tbody>
</table>
# Statement of Revenues and Expenses

## Worksheet G-3

**Provider CCN:** 141308  
**Period:** From 05/01/2014 To 04/30/2015  
**Date/Time Prepared:** 09/24/2015 1:35 pm

### Total Patient Revenues (from Wkst. G-2, Part I, column 3, line 28)
- Amount: 24,929,319  
### Less Contractual Allowances and Discounts on Patients' Accounts
- Amount: 11,180,038  
### Net Patient Revenues (Line 1 minus Line 2)
- Amount: 13,749,281  
### Less Total Operating Expenses (from Wkst. G-2, Part II, line 43)
- Amount: 14,394,399  
### Net Income from Service to Patients (Line 3 minus Line 4)
- Amount: -645,118

### Other Income

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions, donations, bequests, etc</td>
<td>20,402</td>
<td>6.00</td>
</tr>
<tr>
<td>Income from investments</td>
<td>23,646</td>
<td>7.00</td>
</tr>
<tr>
<td>Revenue from telephone and other miscellaneous communication services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchase discounts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rebates and refunds of expenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parking lot receipts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue from laundry and linen service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue from meals sold to employees and guests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue from rental of living quarters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue from sale of medical and surgical supplies to other than patients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue from sale of drugs to other than patients</td>
<td>2,511</td>
<td>17.00</td>
</tr>
<tr>
<td>Revenue from sale of medical records and abstracts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuition (fees, sale of textbooks, uniforms, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue from gifts, flowers, coffee shops, and canteen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rental of vending machines</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rental of hospital space</td>
<td>14,939</td>
<td>22.00</td>
</tr>
<tr>
<td>Governmental appropriations</td>
<td>360,671</td>
<td>23.00</td>
</tr>
</tbody>
</table>

### Grant Income

- Amount: 70,943  
- Amount: 88,673  
- Amount: 699

### Other Miscellaneous Income

- Amount: 35,584

### Total Other Income (sum of Lines 6-24)
- Amount: 618,068  
### Total (Line 5 plus Line 25)
- Amount: -27,050  
### Other Expenses (Spec FY)
- Amount: 0  
### Total Other Expenses (Sum of Line 27 and Subscripts)
- Amount: 0  
### Net Income (or Loss) for the Period (Line 26 minus Line 28)
- Amount: -27,050
## ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

### RURAL HEALTH CLINIC (RHC) I

<table>
<thead>
<tr>
<th>Period:</th>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>05/01/2014</td>
<td>04/30/2015</td>
</tr>
</tbody>
</table>

### Provider CCN: 141308

### Component CCN: 143472

### Date/Time Prepared: 9/24/2015 1:35 pm

### Worksheet M-1

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

<table>
<thead>
<tr>
<th>FACILITY HEALTH CARE STAFF COSTS</th>
<th>Compensation</th>
<th>Other Costs</th>
<th>Total (col. 1 + col. 2)</th>
<th>Reclassification</th>
<th>Reclassified Trial Balance (col. 3 + col. 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00 Physician</td>
<td>742,569</td>
<td>0</td>
<td>742,569</td>
<td>0</td>
<td>742,569</td>
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<tr>
<td>2.00 Physician Assistant</td>
<td>83,200</td>
<td>0</td>
<td>83,200</td>
<td>0</td>
<td>83,200</td>
</tr>
<tr>
<td>3.00 Nurse Practitioner</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4.00 Visiting Nurse</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5.00 Other Nurse</td>
<td>327,816</td>
<td>0</td>
<td>327,816</td>
<td>0</td>
<td>327,816</td>
</tr>
<tr>
<td>6.00 Clinical Psychologist</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7.00 Clinical Social Worker</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8.00 Laboratory Technician</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9.00 Other Facility Health Care Staff Costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10.00 Subtotal (sum of lines 1 through 9)</td>
<td>1,153,585</td>
<td>0</td>
<td>1,153,585</td>
<td>0</td>
<td>1,153,585</td>
</tr>
<tr>
<td>11.00 Physician Services Under Agreement</td>
<td>0</td>
<td>147,660</td>
<td>147,660</td>
<td>0</td>
<td>147,660</td>
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<tr>
<td>12.00 Physician Supervision Under Agreement</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>13.00 Other Costs Under Agreement</td>
<td>0</td>
<td>14,995</td>
<td>14,995</td>
<td>0</td>
<td>14,995</td>
</tr>
<tr>
<td>14.00 Subtotal (sum of lines 11 through 13)</td>
<td>0</td>
<td>162,655</td>
<td>162,655</td>
<td>0</td>
<td>162,655</td>
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<tr>
<td>15.00 Medical Supplies</td>
<td>0</td>
<td>6,394</td>
<td>6,394</td>
<td>0</td>
<td>6,394</td>
</tr>
<tr>
<td>16.00 Transportation (Health Care Staff)</td>
<td>0</td>
<td>2,290</td>
<td>2,290</td>
<td>0</td>
<td>2,290</td>
</tr>
<tr>
<td>17.00 Depreciation-Medical Equipment</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>18.00 Professional Liability Insurance</td>
<td>0</td>
<td>46,387</td>
<td>46,387</td>
<td>-46,387</td>
<td>0</td>
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<tr>
<td>19.00 Other Health Care Costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>20.00 Allowable GME Costs</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>21.00 Subtotal (sum of lines 15 through 20)</td>
<td>0</td>
<td>55,071</td>
<td>55,071</td>
<td>-41,327</td>
<td>13,744</td>
</tr>
<tr>
<td>22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)</td>
<td>1,153,585</td>
<td>217,726</td>
<td>1,371,311</td>
<td>-41,327</td>
<td>1,329,984</td>
</tr>
</tbody>
</table>

### COSTS OTHER THAN RHC/FQHC SERVICES

| Pharmacy                          | 0            | 0           | 0                       | 0                | 0                               |
| Dental                            | 0            | 0           | 0                       | 0                | 0                               |
| Optometry                         | 0            | 0           | 0                       | 0                | 0                               |
| All other nonreimbursable costs   | 0            | 0           | 0                       | 0                | 0                               |
| Nonallowable GME costs            | 0            | 0           | 0                       | 0                | 0                               |
| Total Nonreimbursable Costs (sum of lines 23 through 27) | 0 | 0 | 0 | 0 | 0 |

### FACILITY OVERHEAD

| Facility Costs                    | 0            | 6,859      | 6,859                  | 0                | 6,859                          |
| Administrative Costs              | 0            | 7,470      | 7,470                  | 0                | 7,470                          |
| Total Facility Overhead (sum of lines 29 and 30) | 0 | 14,329 | 14,329 | 0 | 14,329 |
| Total facility costs (sum of lines 22, 28 and 31) | 1,153,585 | 232,055 | 1,385,640 | -41,327 | 1,344,313 |

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MCN F32 - 7.7.157.3
## ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS

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

### FACILITY HEALTH CARE STAFF COSTS

<table>
<thead>
<tr>
<th>Adjustments</th>
<th>Net Expenses for Allocation (col. 5 + col. 6)</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00 Physician</td>
<td>-114,244</td>
<td>628,325</td>
</tr>
<tr>
<td>2.00 Physician Assistant</td>
<td>0</td>
<td>83,200</td>
</tr>
<tr>
<td>3.00 Nurse Practitioner</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4.00 Visiting Nurse</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5.00 Other Nurse</td>
<td>0</td>
<td>327,816</td>
</tr>
<tr>
<td>6.00 Clinical Psychologist</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7.00 Clinical Social Worker</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>8.00 Laboratory Technician</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>9.00 Other Facility Health Care Staff Costs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10.00 Subtotal (sum of lines 1 through 9)</td>
<td>-114,244</td>
<td>1,039,341</td>
</tr>
<tr>
<td>11.00 Physician Services Under Agreement</td>
<td>-6,900</td>
<td>140,760</td>
</tr>
<tr>
<td>12.00 Physician Supervision Under Agreement</td>
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<td>0</td>
</tr>
<tr>
<td>13.00 Other Costs Under Agreement</td>
<td>0</td>
<td>14,995</td>
</tr>
<tr>
<td>14.00 Subtotal (sum of lines 11 through 13)</td>
<td>-6,900</td>
<td>155,755</td>
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<tr>
<td>15.00 Medical Supplies</td>
<td>-6</td>
<td>6,388</td>
</tr>
<tr>
<td>16.00 Transportation (Health Care Staff)</td>
<td>-219</td>
<td>2,071</td>
</tr>
<tr>
<td>17.00 Depreciation-Medical Equipment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>18.00 Professional Liability Insurance</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>19.00 Other Health Care Costs</td>
<td>0</td>
<td>5,060</td>
</tr>
<tr>
<td>20.00 Allowable GME Costs</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>21.00 Subtotal (sum of lines 15 through 20)</td>
<td>-225</td>
<td>13,519</td>
</tr>
<tr>
<td>22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)</td>
<td>-121,369</td>
<td>1,208,615</td>
</tr>
</tbody>
</table>

### COSTS OTHER THAN RHC/FQHC SERVICES

| 23.00 Pharmacy | 0 | 0 |
| 24.00 Dental | 0 | 0 |
| 25.00 Optometry | 0 | 0 |
| 26.00 All other nonreimbursable costs | 0 | 0 |
| 27.00 Nonallowable GME costs | 0 | 0 |
| 28.00 Total Nonreimbursable Costs (sum of lines 23 through 27) | 0 | 0 |

### FACILITY OVERHEAD

| 29.00 Facility Costs | -1,320 | 5,539 |
| 30.00 Administrative Costs | 0 | 7,470 |
| 31.00 Total Facility Overhead (sum of lines 29 and 30) | -1,320 | 13,009 |
| 32.00 Total facility costs (sum of lines 22, 28 and 31) | -122,689 | 1,221,624 |
### ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

**Rural Health Clinic (RHC) 1**

<table>
<thead>
<tr>
<th>Positions</th>
<th>Number of FTE Personnel</th>
<th>Total Visits</th>
<th>Productivity Standard (1)</th>
<th>Minimum Visits (≥ col. 3)</th>
<th>Greater of col. 2 or col. 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00 Physician</td>
<td>2.32</td>
<td>5,227</td>
<td>4,200</td>
<td>9,744</td>
<td>1.00</td>
</tr>
<tr>
<td>2.00 Physician Assistant</td>
<td>0.00</td>
<td>0</td>
<td>2,100</td>
<td>0</td>
<td>2.00</td>
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<td>1,732</td>
<td>2,100</td>
<td>1,512</td>
<td>3.00</td>
</tr>
<tr>
<td>4.00 Subtotal (sum of lines 1 through 3)</td>
<td>3.04</td>
<td>6,959</td>
<td>11,256</td>
<td>11,256</td>
<td>4.00</td>
</tr>
<tr>
<td>5.00 Visiting Nurse</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
<td>5.00</td>
<td></td>
</tr>
<tr>
<td>6.00 Clinical Psychologist</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
<td>6.00</td>
<td></td>
</tr>
<tr>
<td>7.00 Clinical Social Worker</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
<td>7.00</td>
<td></td>
</tr>
<tr>
<td>7.01 Medical Nutrition Therapist (FQHC only)</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
<td>7.01</td>
<td></td>
</tr>
<tr>
<td>7.02 Diabetes Self Management Training (FQHC only)</td>
<td>0.00</td>
<td>0</td>
<td>0</td>
<td>7.02</td>
<td></td>
</tr>
<tr>
<td>8.00 Total FTEs and Visits (sum of lines 4 through 7)</td>
<td>3.04</td>
<td>6,959</td>
<td>11,256</td>
<td>8.00</td>
<td></td>
</tr>
<tr>
<td>9.00 Physician Services Under Agreements</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9.00</td>
<td></td>
</tr>
</tbody>
</table>

**DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES**

<table>
<thead>
<tr>
<th>Lines</th>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.00</td>
<td>Total costs of health care services (from Wkst. M-1, col. 7, line 22)</td>
<td>1,208,615</td>
</tr>
<tr>
<td>11.00</td>
<td>Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)</td>
<td>0</td>
</tr>
<tr>
<td>12.00</td>
<td>Cost of all services (excluding overhead) (sum of lines 10 and 11)</td>
<td>1,208,615</td>
</tr>
<tr>
<td>13.00</td>
<td>Total overhead (sum of lines 14 and 15)</td>
<td>810,721</td>
</tr>
<tr>
<td>14.00</td>
<td>Total facility overhead - (from Wkst. M-1, col. 7, line 31)</td>
<td>13,009</td>
</tr>
<tr>
<td>15.00</td>
<td>Parent provider overhead allocated to facility (see instructions)</td>
<td>797,712</td>
</tr>
<tr>
<td>16.00</td>
<td>Allowable GME overhead (see instructions)</td>
<td>810,721</td>
</tr>
<tr>
<td>17.00</td>
<td>Overhead applicable to RHC/FQHC services (line 13 x line 18)</td>
<td>810,721</td>
</tr>
<tr>
<td>18.00</td>
<td>Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)</td>
<td>2,019,336</td>
</tr>
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</table>
### DETERMINATION OF RATE FOR RHC/FQHC SERVICES

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Cost</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)</td>
<td>2,019,336</td>
<td>1.00</td>
</tr>
<tr>
<td>2.00</td>
<td>Cost of vaccines and their administration (from Wkst. M-4, line 15)</td>
<td>20,518</td>
<td>2.00</td>
</tr>
<tr>
<td>3.00</td>
<td>Total allowable cost excluding vaccine (line 1 minus line 2)</td>
<td>1,998,818</td>
<td>3.00</td>
</tr>
<tr>
<td>4.00</td>
<td>Total Visits (from Worksheet M-2, column 5, line 9)</td>
<td>11,256</td>
<td>4.00</td>
</tr>
<tr>
<td>5.00</td>
<td>Physicians visits under agreement (from Wkst. M-2, column 5, line 9)</td>
<td>0</td>
<td>5.00</td>
</tr>
<tr>
<td>6.00</td>
<td>Total adjusted visits (line 4 plus line 5)</td>
<td>11,256</td>
<td>6.00</td>
</tr>
<tr>
<td>7.00</td>
<td>Adjusted cost per visit (line 3 divided by line 6)</td>
<td>177.58</td>
<td>7.00</td>
</tr>
</tbody>
</table>

### CALCULATION OF SETTLEMENT

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Cost</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.00</td>
<td>Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)</td>
<td>79.80</td>
<td>8.00</td>
</tr>
<tr>
<td>9.00</td>
<td>Rate for Program covered visits (see instructions)</td>
<td>177.58</td>
<td>9.00</td>
</tr>
</tbody>
</table>

### OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.00</td>
<td>Net Medicare cost excluding vaccines (see instructions)</td>
<td>280,434</td>
</tr>
<tr>
<td>21.00</td>
<td>Program cost excluding costs for mental health services (line 9 x line 10)</td>
<td>284,315</td>
</tr>
<tr>
<td>22.00</td>
<td>Total reimbursable Program cost (line 20 plus line 21)</td>
<td>3,881</td>
</tr>
<tr>
<td>23.00</td>
<td>Allowable bad debts (see instructions)</td>
<td>7,650</td>
</tr>
<tr>
<td>24.00</td>
<td>Allowable bad debts for dual eligible beneficiaries (see instructions)</td>
<td>7,650</td>
</tr>
<tr>
<td>25.00</td>
<td>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</td>
<td>0</td>
</tr>
<tr>
<td>26.00</td>
<td>Net reimbursable amount (see instructions)</td>
<td>290,129</td>
</tr>
<tr>
<td>27.00</td>
<td>Interim payments</td>
<td>299,878</td>
</tr>
<tr>
<td>28.00</td>
<td>Tentative settlement (for contractor use only)</td>
<td>0</td>
</tr>
<tr>
<td>29.00</td>
<td>Balance due component/program (line 26 minus lines 26.01, 27, and 28)</td>
<td>-15,552</td>
</tr>
<tr>
<td>30.00</td>
<td>Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter 1, §115.2</td>
<td>0</td>
</tr>
</tbody>
</table>

### Calculation of Limit (1)

<table>
<thead>
<tr>
<th>Prior to January</th>
<th>On or After January</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.00</td>
<td>2.00</td>
</tr>
</tbody>
</table>

### Calculation of Reimbursement Settlement for RHC/FQHC Services

#### Title XVIII

**Rural Health Clinic (RHC)**

#### Worksheet M-3

<table>
<thead>
<tr>
<th>Period</th>
<th>From 05/01/2014 To 04/30/2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider CCN</td>
<td>141308</td>
</tr>
<tr>
<td>Component CCN</td>
<td>143472</td>
</tr>
<tr>
<td>Date/Time Prepared</td>
<td>9/24/2015 1:35 pm</td>
</tr>
</tbody>
</table>

### Calculation of Reimbursement Settlement

- **Total Allowable Cost of RHC/FQHC Services**: $2,019,336
- **Cost of Vaccines and Their Administration**: $20,518
- **Total Adjusted Visits**: 11,256
- **Adjusted Cost per Visit**: $177.58
- **Per Visit Payment Limit**: $79.80
- **Rate for Program Covered Visits**: $177.58

### Allowable Bad Debts

- **Total Allowable Bad Debts**: $280,434
- **Allowable Bad Debts for Dual Eligible Beneficiaries**: $280,434

### Interim Payments

- **Interim Payments**: $299,878

### Other Adjustments

- **Other Adjustments**: $0

### Net Reimbursable Amount

- **Net Reimbursable Amount**: $290,129

### Balance Due Component/Program

- **Balance Due Component/Program**: $-15,552

### Protested Amounts

- **Protested Amounts**: $0

---

**WASHINGTON COUNTY HOSPITAL**

**MCRIF32 - 7.7.157.3**
## COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

<table>
<thead>
<tr>
<th>Title XVIII</th>
<th>Rural Health Clinic (RHC)</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider CCN</td>
<td>141308</td>
<td></td>
</tr>
<tr>
<td>Component CCN</td>
<td>143472</td>
<td></td>
</tr>
<tr>
<td>Period: From 05/01/2014 To 04/30/2015</td>
<td>Worksheet M-4</td>
<td>Date/Time Prepared: 9/24/2015 1:35 pm</td>
</tr>
</tbody>
</table>

### Health care staff cost
- **Pneumococcal**: $1,039,341
- **Influenza**: $1,039,341

### Ratio of pneumococcal and influenza vaccine staff time to total health care staff time
- **Pneumococcal**: 0.001522
- **Influenza**: 0.004140

### Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)
- **Pneumococcal**: $1,582
- **Influenza**: $4,303

### Medical supplies cost - pneumococcal and influenza vaccine (from your records)
- **Pneumococcal**: $3,862
- **Influenza**: $2,534

### Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)
- **Pneumococcal**: $5,444
- **Influenza**: $6,837

### Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)
- **Pneumococcal**: $1,208,615
- **Influenza**: $1,208,615

### Total overhead (from Wkst. M-2, line 16)
- **Pneumococcal**: $810,721
- **Influenza**: $810,721

### Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)
- **Pneumococcal**: 0.004504
- **Influenza**: 0.005657

### Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)
- **Pneumococcal**: $3,651
- **Influenza**: $4,586

### Total health care staff cost and its (their) administration (sum of lines 5 and 9)
- **Pneumococcal**: $9,095
- **Influenza**: $11,423

### Total number of pneumococcal and influenza vaccine injections (from your records)
- **Pneumococcal**: 57
- **Influenza**: 155

### Cost per pneumococcal and influenza vaccine injection (line 10 divided by line 11)
- **Pneumococcal**: $159.56
- **Influenza**: $73.70

### Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries
- **Pneumococcal**: 10
- **Influenza**: 31

### Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)
- **Pneumococcal**: $1,596
- **Influenza**: $2,285

### 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)
- **Pneumococcal**: $20,518

### 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)
- **Pneumococcal**: $3,881
- **Influenza**: $3,881
**ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES**

**Rural Health Clinic (RHC) 1**

<table>
<thead>
<tr>
<th>Period</th>
<th>Cost</th>
<th>Part B</th>
</tr>
</thead>
<tbody>
<tr>
<td>To</td>
<td>From</td>
<td>05/01/2014</td>
</tr>
</tbody>
</table>

**Provider CCN:** 141308  
**Component CCN:** 143472

**Provider to Program**

<table>
<thead>
<tr>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2015</td>
<td>25,610</td>
</tr>
<tr>
<td>04/30/2015</td>
<td>1,404</td>
</tr>
</tbody>
</table>

**Total interim payments paid to provider**

<table>
<thead>
<tr>
<th>Cost</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>275,672</td>
</tr>
<tr>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>3.00</td>
</tr>
</tbody>
</table>

**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**

**Rural Health Clinic (RHC) 1**

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</table>

**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)**

**Provider to Program**

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<tbody>
<tr>
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</table>

**Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M 3, line 27)**

<table>
<thead>
<tr>
<th>Cost</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.99</td>
<td>24,206</td>
</tr>
</tbody>
</table>

**.provider to Program**

**Program to Provider**

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</table>

**List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)**

**Provider to Program**

<table>
<thead>
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<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
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</thead>
<tbody>
<tr>
<td>3.99</td>
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</tr>
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</table>

**To be completed by contractor**

**Program to Provider**

<table>
<thead>
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<th>Date</th>
<th>Amount</th>
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<tbody>
<tr>
<td>01/01/2015</td>
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</table>

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</tr>
<tr>
<td>04/30/2015</td>
<td>1,404</td>
</tr>
</tbody>
</table>

**Determined net settlement amount (balance due) based on the cost report. (1)**

<table>
<thead>
<tr>
<th>Cost</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.00</td>
<td>0</td>
</tr>
</tbody>
</table>

**Total Medicare program liability (see instructions)**

<table>
<thead>
<tr>
<th>Cost</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.00</td>
<td>284,326</td>
</tr>
</tbody>
</table>

**Name of Contractor**

<table>
<thead>
<tr>
<th>Contractor</th>
<th>NPR Date</th>
</tr>
</thead>
<tbody>
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<td>0</td>
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<tr>
<td>0</td>
<td>1.00</td>
</tr>
<tr>
<td>0</td>
<td>1.00</td>
</tr>
<tr>
<td>8.00</td>
<td>7.00</td>
</tr>
</tbody>
</table>