This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141310	Period: From 04/01/2014 To 03/31/2015	Worksheet S Parts I-III Date/Time Prepared: 8/26/2015 10:45 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/26/2015 Time: 10:45 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MENDOTA COMMUNITY HOSPITAL (141310) for the cost reporting period beginning 04/01/2014 and ending 03/31/2015 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

PART III - SETTLEMENT SUMMARY

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital	0	-116,499	1,591	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-34,686	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC (RHC) I	0		0		0	10.00
200.00	Total	0	-151,185	1,591	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 8/26/2015 10:44 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1401 EAST 12TH ST	PO Box:			1.00
2.00	City: MENDOTA	State: IL	Zip Code: 61342-9216	County: LASALLE	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	MENDOTA COMMUNITY HOSPITAL	141310	99914	1	01/15/2001	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MENDOTA COMMUNITY SWING BED- SNF	14Z310	99914		01/25/2001	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MENDOTA COMMUNITY HOSPITAL - HHA	147616	99914		09/15/1995	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	MENDOTA COMMUNITY HOSPITAL - RHC	148535	99914		02/11/2015	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2014	03/31/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

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

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

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	40,413	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

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

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	Y		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141310	Period: From 04/01/2014 To 03/31/2015	Worksheet S-2 Part I Date/Time Prepared: 8/26/2015 10:44 am

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

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

		1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)	N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 8/26/2015 10:44 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
	Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
	Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
		Description	Y/N	Date	Y/N
		0	1.00	2.00	3.00
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	08/06/2015	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 8/26/2015 10:44 am

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

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KEVIN	WELLEN	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(314) 231-5544	STLHEALTHCARE@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 8/26/2015 10:44 am

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	08/06/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		MANAGING DIRECTOR		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 8/26/2015 10:44 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	33,984.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	33,984.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	3,264.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	37,248.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC)	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 8/26/2015 10:44 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	987	113	1,416			1.00
2.00	HMO and other (see instructions)	108	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	940	0	950			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	90			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,927	113	2,456			7.00
8.00	INTENSIVE CARE UNIT	102	0	136			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	2,029	113	2,592	0.00	235.60	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	2,103	0	2,396	0.00	5.35	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC)	0	0	1,559	0.00	2.30	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	243.25	27.00
28.00	Observation Bed Days		127	830			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 8/26/2015 10:44 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	333	33	492	1.00
2.00	HMO and other (see instructions)			36	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	333	33	492	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC (RHC)	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 141310 | Component CCN: 147616 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-4 | Date/Time Prepared: 8/26/2015 10:44 am

Home Health Agency I | PPS

					1.00		
0.00	County				LASALLE		0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	277	0	34	311	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	145.00	0.00	11.00	156.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		40.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.60	0.00	0.60	4.00
5.00	Other Administrative Personnel			0.10	0.00	0.10	5.00
6.00	Direct Nursing Service			3.70	0.00	3.70	6.00
7.00	Nursing Supervisor			0.60	0.00	0.60	7.00
8.00	Physical Therapy Service			0.17	0.22	0.39	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.04	0.00	0.04	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.14	0.00	0.14	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			99914			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	1,251	0	80	16	1,347	21.00
22.00	Skilled Nursing Visit Charges	278,134	0	14,691	3,486	296,311	22.00
23.00	Physical Therapy Visits	490	0	10	8	508	23.00
24.00	Physical Therapy Visit Charges	118,026	0	1,992	1,992	122,010	24.00
25.00	Occupational Therapy Visits	41	0	2	0	43	25.00
26.00	Occupational Therapy Visit Charges	10,209	0	498	0	10,707	26.00
27.00	Speech Pathology Visits	6	0	0	0	6	27.00
28.00	Speech Pathology Visit Charges	1,494	0	0	0	1,494	28.00
29.00	Medical Social Service Visits	5	0	0	0	5	29.00
30.00	Medical Social Service Visit Charges	1,755	0	0	0	1,755	30.00
31.00	Home Health Aide Visits	190	0	0	4	194	31.00
32.00	Home Health Aide Visit Charges	27,448	0	0	584	28,032	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	1,983	0	92	28	2,103	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	437,066	0	17,181	6,062	460,309	35.00
36.00	Total Number of Episodes (standard/non outlier)	152		23	2	177	36.00
37.00	Total Number of Outlier Episodes		0		0	0	37.00
38.00	Total Non-Routine Medical Supply Charges	31,951	0	897	19	32,867	38.00

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

Provider CCN: 141310 Component CCN: 148535 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-8 | Date/Time Prepared: 8/26/2015 10:44 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1405 E. 12TH ST.	1.00

		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County	MENDOTA	IL	61342	2.00

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

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

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

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

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

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

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

			County			
			4.00			
2.00	City, State, Zip Code, County		LASALLE COUNTY			2.00

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

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

Provider CCN: 141310
Component CCN: 148535

Period:
From 04/01/2014
To 03/31/2015

Worksheet S-8

Date/Time Prepared:
8/26/2015 10:44 am

Rural Health Clinic (RHC) I

Cost

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-10 | Date/Time Prepared: 8/26/2015 10:44 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.413379	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,414,129	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	780,370	5.00
6.00	Medicaid charges	8,408,295	6.00
7.00	Medicaid cost (line 1 times line 6)	3,475,813	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)	1,281,314	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,281,314	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	303,375	36,882	340,257	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	125,409	15,246	140,655	21.00
22.00	Partial payment by patients approved for charity care	24,981	0	24,981	22.00
23.00	Cost of charity care (line 21 minus line 22)	100,428	15,246	115,674	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,379,236	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	418,408	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	960,828	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	397,186	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	512,860	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,794,174	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A | Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	3,887,855	3,887,855	1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS		0	0	55,748	55,748	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,668,770	3,668,770	-1,738,789	1,929,981	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,137,518	3,137,518	225,504	3,363,022	4.00
5.01	00540	BUSINESS OFFICE	213,941	223,935	437,876	159,024	596,900	5.01
5.02	00541	DATA PROCESSING	286,326	504,732	791,058	5,721	796,779	5.02
5.03	00542	ADMITTING	236,555	51,490	288,045	0	288,045	5.03
5.04	00543	PURCHASING, RECEIVING AND STORES	52,693	37,884	90,577	0	90,577	5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL	855,792	2,135,970	2,991,762	-466,007	2,525,755	5.05
7.00	00700	OPERATION OF PLANT	384,578	605,408	989,986	-1,938	988,048	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	70,795	70,795	0	70,795	8.00
9.00	00900	HOUSEKEEPING	339,733	50,725	390,458	0	390,458	9.00
10.00	01000	DIETARY	272,733	155,598	428,331	-300,058	128,273	10.00
11.00	01100	CAFETERIA	0	0	0	300,058	300,058	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	149,881	149,881	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	227,230	83,109	310,339	0	310,339	16.00
17.00	01700	SOCIAL SERVICE	183,175	2,097	185,272	0	185,272	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,638,346	180,825	1,819,171	0	1,819,171	30.00
31.00	03100	INTENSIVE CARE UNIT	383,623	52,974	436,597	0	436,597	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	397,490	881,879	1,279,369	-299,318	980,051	50.00
51.00	05100	RECOVERY ROOM	62,261	41,201	103,462	0	103,462	51.00
53.00	05300	ANESTHESIOLOGY	604,228	79,054	683,282	-10,767	672,515	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	576,714	1,228,981	1,805,695	-975,132	830,563	54.00
56.00	05600	RADIOISOTOPE	0	0	0	463,974	463,974	56.00
57.00	05700	CT SCAN	0	0	0	330,652	330,652	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	-501	-501	154,692	154,191	58.00
60.00	06000	LABORATORY	653,080	801,671	1,454,751	0	1,454,751	60.00
64.00	06400	INTRAVENOUS THERAPY	259,842	200,674	460,516	-42,922	417,594	64.00
65.00	06500	RESPIRATORY THERAPY	472,497	48,639	521,136	-15,225	505,911	65.00
66.00	06600	PHYSICAL THERAPY	404,254	77,561	481,815	-13,066	468,749	66.00
67.00	06700	OCCUPATIONAL THERAPY	130,227	13,928	144,155	-3,849	140,306	67.00
68.00	06800	SPEECH PATHOLOGY	0	51,920	51,920	0	51,920	68.00
69.00	06900	ELECTROCARDIOLOGY	32,013	116,125	148,138	0	148,138	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	52,304	120,443	172,747	304,727	477,474	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	229,952	1,057,834	1,287,786	89,319	1,377,105	73.00
75.00	07500	ASC (NON-DISTINCT PART)	162,424	25,050	187,474	0	187,474	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	232,722	232,722	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	766,391	1,893,109	2,659,500	0	2,659,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	303,582	79,169	382,751	16,141	398,892	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		2,024,661	2,024,661	-2,024,661	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,181,984	19,703,228	29,885,212	484,286	30,369,498	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,451,521	988,868	4,440,389	-378,152	4,062,237	192.00
194.00	07950	MARKETING	24,807	119,556	144,363	-105,577	38,786	194.00
194.01	07951	FOUNDATION	50,334	24,476	74,810	-557	74,253	194.01
200.00		TOTAL (SUM OF LINES 118-199)	13,708,646	20,836,128	34,544,774	0	34,544,774	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A | Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-28,719	3,859,136		1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	55,748		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-238,078	1,691,903		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-482,201	2,880,821		4.00
5.01	00540	BUSINESS OFFICE	0	596,900		5.01
5.02	00541	DATA PROCESSING	0	796,779		5.02
5.03	00542	ADMITTING	0	288,045		5.03
5.04	00543	PURCHASING, RECEIVING AND STORES	0	90,577		5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL	-583,350	1,942,405		5.05
7.00	00700	OPERATION OF PLANT	0	988,048		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	70,795		8.00
9.00	00900	HOUSEKEEPING	0	390,458		9.00
10.00	01000	DIETARY	-9,847	118,426		10.00
11.00	01100	CAFETERIA	-90,198	209,860		11.00
13.00	01300	NURSING ADMINISTRATION	0	149,881		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-12,348	297,991		16.00
17.00	01700	SOCIAL SERVICE	0	185,272		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,819,171		30.00
31.00	03100	INTENSIVE CARE UNIT	0	436,597		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-115,039	865,012		50.00
51.00	05100	RECOVERY ROOM	0	103,462		51.00
53.00	05300	ANESTHESIOLOGY	-604,228	68,287		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	830,563		54.00
56.00	05600	RADIOISOTOPE	0	463,974		56.00
57.00	05700	CT SCAN	0	330,652		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	154,191		58.00
60.00	06000	LABORATORY	-17,143	1,437,608		60.00
64.00	06400	INTRAVENOUS THERAPY	-117,600	299,994		64.00
65.00	06500	RESPIRATORY THERAPY	0	505,911		65.00
66.00	06600	PHYSICAL THERAPY	0	468,749		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	140,306		67.00
68.00	06800	SPEECH PATHOLOGY	0	51,920		68.00
69.00	06900	ELECTROCARDIOLOGY	-96,410	51,728		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	477,474		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-405	1,376,700		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	187,474		75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	232,722		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	-883,911	1,775,589		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	398,892		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,279,477	27,090,021		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,062,237		192.00
194.00	07950	MARKETING	0	38,786		194.00
194.01	07951	FOUNDATION	0	74,253		194.01
200.00		TOTAL (SUM OF LINES 118-199)	-3,279,477	31,265,297		200.00

RECLASSIFICATIONS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-6 | Date/Time Prepared: 8/26/2015 10:44 am

	Cost Center	Increases Line #	Increases Salary	Increases Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,921,588	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	81,923	2.00
3.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	21,150	3.00
	0		0	2,024,661	
	D - TO RECLASS CAFETERIA COSTS				
1.00	CAFETERIA	11.00	191,057	109,001	1.00
	0		191,057	109,001	
	E - TO RECLASS OFFSITE CLINIC EXPENSE				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	49,010	1.00
	0		0	49,010	
	F - TO RECLASS BLDG DEPR EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,775,187	1.00
2.00	CAP REL COSTS-OFFSITE MOBS	1.01	0	53,060	2.00
	0		0	1,828,247	
	G - TO RECLASS PHY CLNC OFF EQPMT DPR				
1.00	CAP REL COSTS-OFFSITE MOBS	1.01	0	1,416	1.00
	0		0	1,416	
	H - TO RECLASS PROPERTY INS EXP				
1.00	OTHER CAP REL COSTS	3.00	0	40,476	1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	160,827	2.00
	0		0	201,303	
	I - TO RECLASS WORKERS COMP				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	64,451	1.00
	0		0	64,451	
	J - TO RECLASS HR EXPENSES				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	93,774	67,279	1.00
	0		93,774	67,279	
	K - TO RECLASS IMMPLANTS AND O2 EXP				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	311,203	1.00
2.00		0.00	0	0	2.00
	0		0	311,203	
	L - TO RECLASS DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	89,319	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		0	89,319	
	M - TO RECLASS CENTRAL BILL EXP				
1.00	BUSINESS OFFICE	5.01	55,325	103,699	1.00
	0		55,325	103,699	
	O - TO RECLLASS NURSING ADMIN EXP				
1.00	NURSING ADMINISTRATION	13.00	149,881	0	1.00
	0		149,881	0	
	P - TO RECLASS ADVERTISING EXPENSE				
1.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	118,426	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	0		0	118,426	
	Q - TO RECLASS PT & OT SAL TO HHA				
1.00	HOME HEALTH AGENCY	101.00	16,915	0	1.00
2.00		0.00	0	0	2.00
	0		16,915	0	
	R - TO RECLASS PHY PLNT MAINT EXP				
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	1,938	0	1.00
	0		1,938	0	
	V - TO RECLASS PHYSICIAN ADMIN COSTS				
1.00	OTHER ADMINISTRATIVE & GENERAL	5.05	20,115	0	1.00
	0		20,115	0	
	W - TO RECLASS RADIOLOGY EXPENSES				
1.00	RADIOISOTOPE	56.00	0	463,974	1.00
2.00	CT SCAN	57.00	63,227	267,425	2.00
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	75,810	78,882	3.00
	0		139,037	810,281	

RECLASSIFICATIONS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-6 | Date/Time Prepared: 8/26/2015 10:44 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	X - TELEPHONE EXPENSE				
1.00	DATA PROCESSING	5.02	0	5,721	1.00
	0		0	5,721	
	Y - RHC				
1.00	RURAL HEALTH CLINIC (RHC)	88.00	164,853	68,763	1.00
	TOTALS		164,853	68,763	
500.00	Grand Total: Increases		832,895	5,852,780	500.00

RECLASSIFICATIONS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-6 | Date/Time Prepared: 8/26/2015 10:44 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,024,661	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	0		3.00
	0		0	2,024,661			
	D - TO RECLASS CAFETERIA COSTS						
1.00	DIETARY	10.00	191,057	109,001	0		1.00
	0		191,057	109,001			
	E - TO RECLASS OFFSITE CLINIC EXPENSE						
1.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	49,010	0		1.00
	0		0	49,010			
	F - TO RECLASS BLDG DEPR EXPENSE						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,828,247	9		1.00
2.00		0.00	0	0	9		2.00
	0		0	1,828,247			
	G - TO RECLASS PHY CLNC OFF EQPMT DPR						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1,416	9		1.00
	0		0	1,416			
	H - TO RECLASS PROPERTY INS EXP						
1.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	40,476	0		1.00
2.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	160,827	14		2.00
	0		0	201,303			
	I - TO RECLASS WORKERS COMP						
1.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	64,451	0		1.00
	0		0	64,451			
	J - TO RECLASS HR EXPENSES						
1.00	OTHER ADMINISTRATIVE & GENERAL	5.05	93,774	67,279	0		1.00
	0		93,774	67,279			
	K - TO RECLASS IMMPLANTS AND O2 EXP						
1.00	OPERATING ROOM	50.00	0	299,318	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	11,885	0		2.00
	0		0	311,203			
	L - TO RECLASS DRUGS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,476	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	10,767	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	25,814	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	3,340	0		4.00
5.00	INTRAVENOUS THERAPY	64.00	0	42,922	0		5.00
	0		0	89,319			
	M - TO RECLASS CENTRAL BILL EXP						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	55,325	103,699	0		1.00
	0		55,325	103,699			
	O - TO RECLLASS NURSING ADMIN EXP						
1.00	OTHER ADMINISTRATIVE & GENERAL	5.05	149,881	0	0		1.00
	0		149,881	0			
	P - TO RECLASS ADVERTISING EXPENSE						
1.00	HOME HEALTH AGENCY	101.00	0	774	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	10,624	0		2.00
3.00	MARKETING	194.00	0	105,577	0		3.00
4.00	FOUNDATION	194.01	0	557	0		4.00
5.00	RURAL HEALTH CLINIC (RHC)	88.00	0	894	0		5.00
	0		0	118,426			
	Q - TO RECLASS PT & OT SAL TO HHA						
1.00	PHYSICAL THERAPY	66.00	13,066	0	0		1.00
2.00	OCCUPATIONAL THERAPY	67.00	3,849	0	0		2.00
	0		16,915	0			
	R - TO RECLASS PHY PLNT MAINT EXP						
1.00	OPERATION OF PLANT	7.00	1,938	0	0		1.00
	0		1,938	0			
	V - TO RECLASS PHYSICIAN ADMIN COSTS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	20,115	0	0		1.00
	0		20,115	0			
	W - TO RECLASS RADIOLOGY EXPENSES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	139,037	810,281	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	0		139,037	810,281			

RECLASSIFICATIONS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-6 | Date/Time Prepared: 8/26/2015 10:44 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	X - TELEPHONE EXPENSE						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,721	0		1.00
	0		0	5,721			
	Y - RHC						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	164,853	68,763	0		1.00
	TOTALS		164,853	68,763			
500.00	Grand Total: Decreases		832,895	5,852,780			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 8/26/2015 10:44 am

			Acquisitions				
		Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,272,124	0	0	0	2,178	1.00
2.00	Land Improvements	4,977,101	0	0	0	0	2.00
3.00	Buildings and Fixtures	30,822,579	0	0	0	137,755	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	4,252,077	0	0	0	0	5.00
6.00	Movable Equipment	9,782,077	367,626	0	367,626	130,478	6.00
7.00	HIT designated Assets	902,039	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,007,997	367,626	0	367,626	270,411	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	52,007,997	367,626	0	367,626	270,411	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	1,269,946	0	1.00
2.00	Land Improvements	4,977,101	0	2.00
3.00	Buildings and Fixtures	30,684,824	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,252,077	0	5.00
6.00	Movable Equipment	10,019,225	0	6.00
7.00	HIT designated Assets	902,039	0	7.00
8.00	Subtotal (sum of lines 1-7)	52,105,212	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	52,105,212	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 8/26/2015 10:44 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	3,668,770	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,668,770	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,668,770	2.00
3.00	Total (sum of lines 1-2)	0	3,668,770	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 8/26/2015 10:44 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	35,442,013	0	35,442,013	0.747440	30,253	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	1,489,858	0	1,489,858	0.031420	1,272	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	15,173,341	4,687,352	10,485,989	0.221140	8,951	2.00
3.00	Total (sum of lines 1-2)	52,105,212	4,687,352	47,417,860	1.000000	40,476	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	30,253	1,775,187	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	1,272	54,476	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	8,951	1,602,253	0	2.00
3.00	Total (sum of lines 1-2)	0	0	40,476	3,431,916	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	1,892,869	30,253	0	160,827	3,859,136	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	1,272	0	0	55,748	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	80,699	8,951	0	0	1,691,903	2.00
3.00	Total (sum of lines 1-2)	1,973,568	40,476	0	160,827	5,606,787	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-8 | Date/Time Prepared: 8/26/2015 10:44 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-28,719	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - CAP REL COSTS-OFFSITE MOBS (chapter 2)		0	CAP REL COSTS-OFFSITE MOBS	1.01	0	1.01
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-1,224	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)	B	-316	OTHER ADMINISTRATIVE & GENERAL	5.05	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	B	-76	OTHER ADMINISTRATIVE & GENERAL	5.05	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-13,305	OTHER ADMINISTRATIVE & GENERAL	5.05	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-46,567	OTHER ADMINISTRATIVE & GENERAL	5.05	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1,824,016			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-65,801	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-405	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-12,348	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-1,652	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-OFFSITE MOBS		0	CAP REL COSTS-OFFSITE MOBS	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-8 | Date/Time Prepared: 8/26/2015 10:44 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-236,854	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	DIETARY REVENUE	B	-9,847	DIETARY	10.00	0	33.00
33.01	MEALS ON WHEELS	B	-22,745	CAFETERIA	11.00	0	33.01
33.02	AMBULANCE SUPPLY REVENUE	B	-10,315	EMERGENCY	91.00	0	33.02
33.03	LAB QUALITY CN REVENUE	B	-20,083	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.03
33.04	MISCELLANEOUS INCOME	B	-17,743	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.04
33.05	ADVERTISING EXPENSE	A	-58,975	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.05
33.06	COMMUNITY HEALTH EXPENSE	A	-66,049	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.06
33.07	COMMUNITY HEALTH BENEFIT EXPENSE	A	-14,560	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.07
33.08	LOBBYING EXPENSE	A	-12,970	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.08
33.09	CRNA BENEFIT EXPENSE	A	-50,867	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.09
33.10	PROVIDER TAX IDPA EXPENSE	A	-469,231	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.10
33.11	PHYSICIAN RECRUITING EXPENSE	A	-69,106	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.11
33.12	MERGER EXPENSE	A	-225,703	OTHER ADMINISTRATIVE & GENERAL	5.05	0	33.12
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,279,477				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 8/26/2015 10:44 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	30,000	17,143	12,857	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	96,410	96,410	0	0	0	2.00
3.00	91.00	EMERGENCY	1,732,078	873,596	858,482	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	604,228	604,228	0	0	0	4.00
5.00	64.00	INTRAVENOUS THERAPY	117,600	117,600	0	0	0	5.00
6.00	50.00	OPERATING ROOM	115,039	115,039	0	0	0	6.00
7.00	5.05	OTHER ADMINISTRATIVE & GENERAL	20,115	0	20,115	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,715,470	1,824,016	891,454		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	91.00	EMERGENCY	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	64.00	INTRAVENOUS THERAPY	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00	5.05	OTHER ADMINISTRATIVE & GENERAL	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	0	17,143		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	96,410		2.00
3.00	91.00	EMERGENCY	0	0	0	873,596		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	604,228		4.00
5.00	64.00	INTRAVENOUS THERAPY	0	0	0	117,600		5.00
6.00	50.00	OPERATING ROOM	0	0	0	115,039		6.00
7.00	5.05	OTHER ADMINISTRATIVE & GENERAL	0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,824,016		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/26/2015 10:44 am

Physical Therapy | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					13	1.00
2.00	Line 1 multiplied by 15 hours per week					195	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					119	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	634.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	76.57	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.29	38.29	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					48,584	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					48,584	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					48,584	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					48,584	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					4,557	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					4,557	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					655	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					5,212	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					5,212	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 8/26/2015 10:44 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.57	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	48,584		57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	5,212		58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0		59.00
60.00	Overtime allowance (from column 5, line 56)	0		60.00
61.00	Equipment cost (see instructions)	0		61.00
62.00	Supplies (see instructions)	0		62.00
63.00	Total allowance (sum of lines 57-62)	53,796		63.00
64.00	Total cost of outside supplier services (from your records)	44,567		64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0		65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	4,557		100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	655		100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	5,212		100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	655		101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		101.01
101.02	Line 34 = sum of lines 27 and 31	655		101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0		102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0		102.01
102.02	Line 35 = sum of lines 31 and 32	0		102.02

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		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		2	1.00
2.00	Line 1 multiplied by 15 hours per week		30	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		8	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.50	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	43.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.58	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.29	36.29	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	3,121	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	3,121	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	3,121	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22.00
23.00	Total salary equivalency (see instructions)	3,121	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	290	24.00
25.00	Assistants (line 4 times column 3, line 11)	0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	290	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	44	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	334	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	334	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.58	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	3,121	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	334	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	3,455	63.00
64.00	Total cost of outside supplier services (from your records)	3,099	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	290	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	44	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	334	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	44	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	44	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

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Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					9	1.00
2.00	Line 1 multiplied by 15 hours per week					135	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					138	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	824.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.74	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.87	34.87	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					57,501	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					57,501	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					57,501	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					57,501	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					4,812	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					4,812	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					759	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					5,571	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					5,571	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

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Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.74	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	57,501	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	5,571	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	0	62.00
63.00	Total allowance (sum of lines 57-62)	63,072	63.00
64.00	Total cost of outside supplier services (from your records)	51,274	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	4,812	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	759	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	5,571	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	759	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	759	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part I Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,859,136	3,859,136				1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	55,748	0	55,748			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,691,903			1,691,903		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,880,821	5,444	0	2,665	2,888,930	4.00
5.01	00540	BUSINESS OFFICE	596,900	51,349	0	25,141	60,071	5.01
5.02	00541	DATA PROCESSING	796,779	59,958	0	29,356	63,877	5.02
5.03	00542	ADMITTING	288,045	31,659	0	15,500	52,774	5.03
5.04	00543	PURCHASING, RECEIVING AND STORES	90,577	14,053	0	6,881	11,755	5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL	1,942,405	751,584	0	367,979	127,407	5.05
7.00	00700	OPERATION OF PLANT	988,048	173,079	0	84,741	85,364	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	70,795	18,300	0	8,960	0	8.00
9.00	00900	HOUSEKEEPING	390,458	42,237	0	20,680	75,792	9.00
10.00	01000	DIETARY	118,426	105,052	0	51,434	18,221	10.00
11.00	01100	CAFETERIA	209,860	41,465	0	20,301	42,623	11.00
13.00	01300	NURSING ADMINISTRATION	149,881	13,706	0	6,710	33,437	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	297,991	34,245	0	16,767	50,693	16.00
17.00	01700	SOCIAL SERVICE	185,272	11,544	0	5,652	40,865	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,819,171	589,814	0	288,776	365,502	30.00
31.00	03100	INTENSIVE CARE UNIT	436,597	89,339	0	43,741	85,583	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	865,012	168,755	0	82,624	88,677	50.00
51.00	05100	RECOVERY ROOM	103,462	29,844	0	14,612	13,890	51.00
53.00	05300	ANESTHESIOLOGY	68,287	4,980	0	2,438	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	830,563	147,637	0	72,284	97,642	54.00
56.00	05600	RADIOISOTOPE	463,974	26,524	0	12,986	0	56.00
57.00	05700	CT SCAN	330,652	17,875	0	8,752	14,105	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	154,191	40,036	0	19,602	16,913	58.00
60.00	06000	LABORATORY	1,437,608	73,278	0	35,877	145,697	60.00
64.00	06400	INTRAVENOUS THERAPY	299,994	173,427	0	84,911	57,969	64.00
65.00	06500	RESPIRATORY THERAPY	505,911	83,586	0	40,924	105,410	65.00
66.00	06600	PHYSICAL THERAPY	468,749	83,818	0	41,038	87,271	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,306	15,984	0	7,826	28,194	67.00
68.00	06800	SPEECH PATHOLOGY	51,920	3,899	0	1,909	0	68.00
69.00	06900	ELECTROCARDIOLOGY	51,728	3,938	0	1,928	7,142	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	477,474	107,986	0	52,871	11,669	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,376,700	30,539	0	14,952	51,300	73.00
75.00	07500	ASC (NON-DISTINCT PART)	187,474	159,489	0	78,087	36,235	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	232,722	30,037	0	0	36,777	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,775,589	191,032	0	93,530	170,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	398,892	0	0	22,683	71,500	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,090,021	3,425,492	0	1,685,118	2,155,331	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,343	0	4,574	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,062,237	419,784	55,748	0	716,836	192.00
194.00	07950	MARKETING	38,786	2,278	0	1,115	5,534	194.00
194.01	07951	FOUNDATION	74,253	2,239	0	1,096	11,229	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	31,265,297	3,859,136	55,748	1,691,903	2,888,930	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part I Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	Subtotal	BUSINESS OFFICE	DATA PROCESSING	Subtotal	ADMITTING	
			4A	5.01	5.02	5A.02	5.03	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	BUSINESS OFFICE	733,461	733,461				5.01
5.02	00541	DATA PROCESSING	949,970	22,821	972,791			5.02
5.03	00542	ADMITTING	387,978	9,320	27,015	424,313	424,313	5.03
5.04	00543	PURCHASING, RECEIVING AND STORES	123,266	2,961	9,772	135,999	2,302	5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL	3,189,375	76,618	82,853	3,348,846	56,677	5.05
7.00	00700	OPERATION OF PLANT	1,331,232	31,980	218,825	1,582,037	26,779	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	98,055	2,356	0	100,411	1,700	8.00
9.00	00900	HOUSEKEEPING	529,167	12,712	88,294	630,173	10,667	9.00
10.00	01000	DIETARY	293,133	7,042	2,077	302,252	5,116	10.00
11.00	01100	CAFETERIA	314,249	7,549	4,854	326,652	5,529	11.00
13.00	01300	NURSING ADMINISTRATION	203,734	4,894	0	208,628	3,531	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	399,696	9,602	68,152	477,450	8,082	16.00
17.00	01700	SOCIAL SERVICE	243,333	5,846	7,214	256,393	4,340	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,063,263	73,589	111,608	3,248,460	54,987	30.00
31.00	03100	INTENSIVE CARE UNIT	655,260	15,741	13,088	684,089	11,580	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,205,068	28,949	37,391	1,271,408	21,521	50.00
51.00	05100	RECOVERY ROOM	161,808	3,887	0	165,695	2,805	51.00
53.00	05300	ANESTHESIOLOGY	75,705	1,819	0	77,524	1,312	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,148,126	27,581	6,126	1,181,833	20,005	54.00
56.00	05600	RADIOISOTOPE	503,484	12,095	18,893	534,472	9,047	56.00
57.00	05700	CT SCAN	371,384	8,922	12,733	393,039	6,653	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	230,742	5,543	7,869	244,154	4,133	58.00
60.00	06000	LABORATORY	1,692,460	40,658	31,091	1,764,209	29,863	60.00
64.00	06400	INTRAVENOUS THERAPY	616,301	14,805	0	631,106	10,683	64.00
65.00	06500	RESPIRATORY THERAPY	735,831	17,677	29,215	782,723	13,249	65.00
66.00	06600	PHYSICAL THERAPY	680,876	16,357	11,614	708,847	11,999	66.00
67.00	06700	OCCUPATIONAL THERAPY	192,310	4,620	6,242	203,172	3,439	67.00
68.00	06800	SPEECH PATHOLOGY	57,728	1,387	0	59,115	1,001	68.00
69.00	06900	ELECTROCARDIOLOGY	64,736	1,555	61	66,352	1,123	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	650,000	15,615	7,624	673,239	11,396	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,473,491	35,398	6,344	1,515,233	25,648	73.00
75.00	07500	ASC (NON-DISTINCT PART)	461,285	11,081	5,884	478,250	8,095	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	299,536	7,196	17,901	324,633	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,231,127	53,598	54,371	2,339,096	39,594	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			0		92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	493,075	11,845	12,092	517,012	8,751	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,860,245	603,619	899,203	25,656,815	421,607	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	13,917	334	0	14,251	241	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,254,605	126,228	67,756	5,448,589	0	192.00
194.00	07950	MARKETING	47,713	1,146	2,916	51,775	876	194.00
194.01	07951	FOUNDATION	88,817	2,134	2,916	93,867	1,589	194.01
200.00		Cross Foot Adjustments	0			0		200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	31,265,297	733,461	972,791	31,265,297	424,313	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part I | Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	PURCHASING, RECEIVING AND STORES	Subtotal	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			5.04	5A.04	5.05	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	BUSINESS OFFICE						5.01
5.02	00541	DATA PROCESSING						5.02
5.03	00542	ADMITTING						5.03
5.04	00543	PURCHASING, RECEIVING AND STORES	138,301					5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL	3,959	3,409,482	3,409,482			5.05
7.00	00700	OPERATION OF PLANT	2,218	1,611,034	197,186	1,808,220		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	102,111	12,498	11,937	126,546	8.00
9.00	00900	HOUSEKEEPING	2,152	642,992	78,700	27,552	0	9.00
10.00	01000	DIETARY	417	307,785	37,672	68,527	0	10.00
11.00	01100	CAFETERIA	0	332,181	40,658	27,048	0	11.00
13.00	01300	NURSING ADMINISTRATION	975	213,134	26,087	8,940	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	383	485,915	59,475	22,339	0	16.00
17.00	01700	SOCIAL SERVICE	154	260,887	31,932	7,530	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	12,208	3,315,655	405,826	384,743	41,109	30.00
31.00	03100	INTENSIVE CARE UNIT	602	696,271	85,221	58,277	4,159	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,416	1,319,345	161,484	110,081	14,444	50.00
51.00	05100	RECOVERY ROOM	0	168,500	20,624	19,468	0	51.00
53.00	05300	ANESTHESIOLOGY	4,765	83,601	10,233	3,249	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,006	1,202,844	147,224	96,305	7,771	54.00
56.00	05600	RADIOISOTOPE	181	543,700	66,547	17,302	1,396	56.00
57.00	05700	CT SCAN	122	399,814	48,936	11,660	941	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	273	248,560	30,423	26,116	2,107	58.00
60.00	06000	LABORATORY	47,654	1,841,726	225,422	47,800	0	60.00
64.00	06400	INTRAVENOUS THERAPY	3,365	645,154	78,965	113,129	427	64.00
65.00	06500	RESPIRATORY THERAPY	2,174	798,146	97,691	54,524	1,940	65.00
66.00	06600	PHYSICAL THERAPY	2,846	723,692	88,578	54,675	11,979	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,061	207,672	25,418	10,426	2,890	67.00
68.00	06800	SPEECH PATHOLOGY	13	60,129	7,360	2,544	0	68.00
69.00	06900	ELECTROCARDIOLOGY	608	68,083	8,333	2,569	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	308	684,943	83,835	70,441	154	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	808	1,541,689	188,698	19,921	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,628	488,973	59,849	104,037	5,263	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	728	325,361	39,823	19,594	518	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	9,433	2,388,123	292,299	124,613	29,487	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	563	526,326	64,421	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	128,020	25,643,828	2,721,418	1,525,347	124,585	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	14,492	1,774	6,095	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,950	5,458,539	668,122	273,831	1,961	192.00
194.00	07950	MARKETING	113	52,764	6,458	1,486	0	194.00
194.01	07951	FOUNDATION	218	95,674	11,710	1,461	0	194.01
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	138,301	31,265,297	3,409,482	1,808,220	126,546	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part I Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	BUSINESS OFFICE						5.01
5.02	00541	DATA PROCESSING						5.02
5.03	00542	ADMITTING						5.03
5.04	00543	PURCHASING, RECEIVING AND STORES						5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	749,244					9.00
10.00	01000	DIETARY	10,722	424,706				10.00
11.00	01100	CAFETERIA	21,625	297,519	719,031			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	8,877	257,038		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,908	0	26,631	0	597,268	16.00
17.00	01700	SOCIAL SERVICE	0	0	13,315	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	214,069	111,908	159,788	131,146	227,770	30.00
31.00	03100	INTENSIVE CARE UNIT	17,991	5,387	26,631	22,914	739	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,979	0	31,069	17,272	0	50.00
51.00	05100	RECOVERY ROOM	7,087	0	4,438	2,131	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,984	0	35,508	0	47,821	54.00
56.00	05600	RADIOISOTOPE	5,452	0	0	0	8,627	56.00
57.00	05700	CT SCAN	3,634	0	4,438	0	5,669	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	8,178	0	4,438	0	13,064	58.00
60.00	06000	LABORATORY	20,716	0	62,138	0	6,902	60.00
64.00	06400	INTRAVENOUS THERAPY	24,896	1,344	26,631	11,314	60,392	64.00
65.00	06500	RESPIRATORY THERAPY	15,628	0	39,946	0	11,585	65.00
66.00	06600	PHYSICAL THERAPY	20,716	0	31,069	0	10,106	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,543	0	8,877	0	4,190	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	246	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	4,438	1,209	6,902	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	5,815	0	8,877	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,541	0	13,315	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	37,617	5,989	17,754	8,413	36,728	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	11,449	0	8,877	0	4,930	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	69,600	2,559	66,577	44,404	83,810	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,359	0	0	17,119	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	589,509	424,706	603,632	255,922	529,481	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	159,735	0	106,523	1,116	67,787	192.00
194.00	07950	MARKETING	0	0	4,438	0	0	194.00
194.01	07951	FOUNDATION	0	0	4,438	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	749,244	424,706	719,031	257,038	597,268	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part I | Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	BUSINESS OFFICE						5.01
5.02	00541	DATA PROCESSING						5.02
5.03	00542	ADMITTING						5.03
5.04	00543	PURCHASING, RECEIVING AND STORES						5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	313,664					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	274,498	5,266,512	0	5,266,512		30.00
31.00	03100	INTENSIVE CARE UNIT	10,217	927,807	0	927,807		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,693,674	0	1,693,674		50.00
51.00	05100	RECOVERY ROOM	0	222,248	0	222,248		51.00
53.00	05300	ANESTHESIOLOGY	0	97,083	0	97,083		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,567,457	0	1,567,457		54.00
56.00	05600	RADIOISOTOPE	0	643,024	0	643,024		56.00
57.00	05700	CT SCAN	0	475,092	0	475,092		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	332,886	0	332,886		58.00
60.00	06000	LABORATORY	0	2,204,704	0	2,204,704		60.00
64.00	06400	INTRAVENOUS THERAPY	0	962,252	0	962,252		64.00
65.00	06500	RESPIRATORY THERAPY	0	1,019,460	0	1,019,460		65.00
66.00	06600	PHYSICAL THERAPY	0	940,815	0	940,815		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	264,016	0	264,016		67.00
68.00	06800	SPEECH PATHOLOGY	0	70,279	0	70,279		68.00
69.00	06900	ELECTROCARDIOLOGY	0	91,534	0	91,534		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	854,065	0	854,065		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,772,164	0	1,772,164		73.00
75.00	07500	ASC (NON-DISTINCT PART)	14,985	779,608	0	779,608		75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	410,552	0	410,552		88.00
90.00	09000	CLINIC	0	0	0	0		90.00
91.00	09100	EMERGENCY	12,942	3,114,414	0	3,114,414		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	1,022	617,247	0	617,247		101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	313,664	24,326,893	0	24,326,893		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	22,361	0	22,361		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	6,737,614	0	6,737,614		192.00
194.00	07950	MARKETING	0	65,146	0	65,146		194.00
194.01	07951	FOUNDATION	0	113,283	0	113,283		194.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	313,664	31,265,297	0	31,265,297		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part II Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS OFFSITE MOBS	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	5,444	0	2,665	8,109	4.00
5.01	00540	BUSINESS OFFICE	0	51,349	0	25,141	76,490	5.01
5.02	00541	DATA PROCESSING	0	59,958	0	29,356	89,314	5.02
5.03	00542	ADMITTING	0	31,659	0	15,500	47,159	5.03
5.04	00543	PURCHASING, RECEIVING AND STORES	0	14,053	0	6,881	20,934	5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL	2,803	751,584	0	367,979	1,122,366	5.05
7.00	00700	OPERATION OF PLANT	0	173,079	0	84,741	257,820	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,300	0	8,960	27,260	8.00
9.00	00900	HOUSEKEEPING	0	42,237	0	20,680	62,917	9.00
10.00	01000	DIETARY	0	105,052	0	51,434	156,486	10.00
11.00	01100	CAFETERIA	0	41,465	0	20,301	61,766	11.00
13.00	01300	NURSING ADMINISTRATION	0	13,706	0	6,710	20,416	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	34,245	0	16,767	51,012	16.00
17.00	01700	SOCIAL SERVICE	0	11,544	0	5,652	17,196	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	589,814	0	288,776	878,590	30.00
31.00	03100	INTENSIVE CARE UNIT	0	89,339	0	43,741	133,080	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	168,755	0	82,624	251,379	50.00
51.00	05100	RECOVERY ROOM	0	29,844	0	14,612	44,456	51.00
53.00	05300	ANESTHESIOLOGY	0	4,980	0	2,438	7,418	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	147,637	0	72,284	219,921	54.00
56.00	05600	RADIOISOTOPE	0	26,524	0	12,986	39,510	56.00
57.00	05700	CT SCAN	0	17,875	0	8,752	26,627	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	40,036	0	19,602	59,638	58.00
60.00	06000	LABORATORY	0	73,278	0	35,877	109,155	60.00
64.00	06400	INTRAVENOUS THERAPY	0	173,427	0	84,911	258,338	64.00
65.00	06500	RESPIRATORY THERAPY	0	83,586	0	40,924	124,510	65.00
66.00	06600	PHYSICAL THERAPY	0	83,818	0	41,038	124,856	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	15,984	0	7,826	23,810	67.00
68.00	06800	SPEECH PATHOLOGY	0	3,899	0	1,909	5,808	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,938	0	1,928	5,866	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	107,986	0	52,871	160,857	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	30,539	0	14,952	45,491	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	159,489	0	78,087	237,576	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	30,037	0	0	30,037	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	191,032	0	93,530	284,562	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	8,712	0	0	22,683	31,395	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,515	3,425,492	0	1,685,118	5,122,125	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	9,343	0	4,574	13,917	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,626	419,784	55,748	0	497,158	192.00
194.00	07950	MARKETING	0	2,278	0	1,115	3,393	194.00
194.01	07951	FOUNDATION	0	2,239	0	1,096	3,335	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	33,141	3,859,136	55,748	1,691,903	5,639,928	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part II | Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	DATA PROCESSING	ADMITTING	PURCHASING, RECEIVING AND STORES	
			4.00	5.01	5.02	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,109					4.00
5.01	00540	BUSINESS OFFICE	169	76,659				5.01
5.02	00541	DATA PROCESSING	179	2,385	91,878			5.02
5.03	00542	ADMITTING	148	974	2,552	50,833		5.03
5.04	00543	PURCHASING, RECEIVING AND STORES	33	310	923	276	22,476	5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL	358	8,009	7,825	6,787	643	5.05
7.00	00700	OPERATION OF PLANT	240	3,343	20,669	3,208	360	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	246	0	204	0	8.00
9.00	00900	HOUSEKEEPING	213	1,329	8,339	1,278	350	9.00
10.00	01000	DIETARY	51	736	196	613	68	10.00
11.00	01100	CAFETERIA	120	789	458	662	0	11.00
13.00	01300	NURSING ADMINISTRATION	94	512	0	423	159	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	142	1,004	6,437	968	62	16.00
17.00	01700	SOCIAL SERVICE	115	611	681	520	25	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,026	7,692	10,541	6,588	1,984	30.00
31.00	03100	INTENSIVE CARE UNIT	240	1,645	1,236	1,387	98	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	249	3,026	3,532	2,578	4,293	50.00
51.00	05100	RECOVERY ROOM	39	406	0	336	0	51.00
53.00	05300	ANESTHESIOLOGY	0	190	0	157	774	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	274	2,883	579	2,397	163	54.00
56.00	05600	RADIOISOTOPE	0	1,264	1,784	1,084	29	56.00
57.00	05700	CT SCAN	40	933	1,203	797	20	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	47	579	743	495	44	58.00
60.00	06000	LABORATORY	409	4,250	2,936	3,578	7,747	60.00
64.00	06400	INTRAVENOUS THERAPY	163	1,548	0	1,280	547	64.00
65.00	06500	RESPIRATORY THERAPY	296	1,848	2,759	1,587	353	65.00
66.00	06600	PHYSICAL THERAPY	245	1,710	1,097	1,438	463	66.00
67.00	06700	OCCUPATIONAL THERAPY	79	483	590	412	172	67.00
68.00	06800	SPEECH PATHOLOGY	0	145	0	120	2	68.00
69.00	06900	ELECTROCARDIOLOGY	20	163	6	135	99	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	33	1,632	720	1,365	50	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	144	3,700	599	3,073	131	73.00
75.00	07500	ASC (NON-DISTINCT PART)	102	1,158	556	970	427	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	103	752	1,691	0	118	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	480	5,602	5,135	4,744	1,533	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	201	1,238	1,142	1,049	92	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,052	63,095	84,929	50,509	20,806	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	35	0	29	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,009	13,186	6,399	0	1,617	192.00
194.00	07950	MARKETING	16	120	275	105	18	194.00
194.01	07951	FOUNDATION	32	223	275	190	35	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,109	76,659	91,878	50,833	22,476	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part II | Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.05	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	BUSINESS OFFICE						5.01
5.02	00541	DATA PROCESSING						5.02
5.03	00542	ADMITTING						5.03
5.04	00543	PURCHASING, RECEIVING AND STORES						5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL	1,145,988					5.05
7.00	00700	OPERATION OF PLANT	66,278	351,918				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	4,201	2,323	34,234			8.00
9.00	00900	HOUSEKEEPING	26,453	5,362	0	106,241		9.00
10.00	01000	DIETARY	12,662	13,337	0	1,520	185,669	10.00
11.00	01100	CAFETERIA	13,666	5,264	0	3,066	130,066	11.00
13.00	01300	NURSING ADMINISTRATION	8,768	1,740	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,991	4,348	0	412	0	16.00
17.00	01700	SOCIAL SERVICE	10,733	1,466	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	136,406	74,881	11,121	30,355	48,923	30.00
31.00	03100	INTENSIVE CARE UNIT	28,645	11,342	1,125	2,551	2,355	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,278	21,424	3,908	5,669	0	50.00
51.00	05100	RECOVERY ROOM	6,932	3,789	0	1,005	0	51.00
53.00	05300	ANESTHESIOLOGY	3,439	632	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	49,485	18,743	2,102	4,252	0	54.00
56.00	05600	RADIOISOTOPE	22,368	3,367	378	773	0	56.00
57.00	05700	CT SCAN	16,448	2,269	254	515	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	10,226	5,083	570	1,160	0	58.00
60.00	06000	LABORATORY	75,769	9,303	0	2,938	0	60.00
64.00	06400	INTRAVENOUS THERAPY	26,542	22,017	115	3,530	588	64.00
65.00	06500	RESPIRATORY THERAPY	32,836	10,612	525	2,216	0	65.00
66.00	06600	PHYSICAL THERAPY	29,773	10,641	3,241	2,938	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,544	2,029	782	644	0	67.00
68.00	06800	SPEECH PATHOLOGY	2,474	495	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,801	500	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	28,179	13,709	42	825	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	63,425	3,877	0	1,211	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	20,116	20,248	1,424	5,334	2,618	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	13,385	3,813	140	1,623	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	98,247	24,252	7,977	9,869	1,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	21,653	0	0	1,185	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	914,723	296,866	33,704	83,591	185,669	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	596	1,186	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	224,562	53,293	530	22,650	0	192.00
194.00	07950	MARKETING	2,171	289	0	0	0	194.00
194.01	07951	FOUNDATION	3,936	284	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,145,988	351,918	34,234	106,241	185,669	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part II Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	
			11.00	13.00	16.00	17.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	BUSINESS OFFICE						5.01
5.02	00541	DATA PROCESSING						5.02
5.03	00542	ADMITTING						5.03
5.04	00543	PURCHASING, RECEIVING AND STORES						5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	215,857					11.00
13.00	01300	NURSING ADMINISTRATION	2,665	34,777				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,995	0	92,371			16.00
17.00	01700	SOCIAL SERVICE	3,997	0	0	35,344		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	47,970	17,744	35,227	30,931	1,339,979	30.00
31.00	03100	INTENSIVE CARE UNIT	7,995	3,100	114	1,151	196,064	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,327	2,337	0	0	362,000	50.00
51.00	05100	RECOVERY ROOM	1,332	288	0	0	58,583	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	12,610	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,660	0	7,396	0	318,855	54.00
56.00	05600	RADIOISOTOPE	0	0	1,334	0	71,891	56.00
57.00	05700	CT SCAN	1,332	0	877	0	51,315	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,332	0	2,020	0	81,937	58.00
60.00	06000	LABORATORY	18,654	0	1,067	0	235,806	60.00
64.00	06400	INTRAVENOUS THERAPY	7,995	1,531	9,340	0	333,534	64.00
65.00	06500	RESPIRATORY THERAPY	11,992	0	1,792	0	191,326	65.00
66.00	06600	PHYSICAL THERAPY	9,327	0	1,563	0	187,292	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,665	0	648	0	40,858	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	38	0	9,082	68.00
69.00	06900	ELECTROCARDIOLOGY	1,332	164	1,067	0	12,153	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,665	0	0	0	210,077	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,997	0	0	0	125,648	73.00
75.00	07500	ASC (NON-DISTINCT PART)	5,330	1,138	5,680	1,689	304,366	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	2,665	0	762	0	55,089	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	19,987	6,008	12,962	1,458	483,935	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	2,316	0	115	60,386	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	181,214	34,626	81,887	35,344	4,742,786	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	15,763	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	31,979	151	10,484	0	864,018	192.00
194.00	07950	MARKETING	1,332	0	0	0	7,719	194.00
194.01	07951	FOUNDATION	1,332	0	0	0	9,642	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	215,857	34,777	92,371	35,344	5,639,928	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part II | Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00540	BUSINESS OFFICE				5.01
5.02	00541	DATA PROCESSING				5.02
5.03	00542	ADMITTING				5.03
5.04	00543	PURCHASING, RECEIVING AND STORES				5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL				5.05
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	1,339,979		30.00
31.00	03100	INTENSIVE CARE UNIT	0	196,064		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	362,000		50.00
51.00	05100	RECOVERY ROOM	0	58,583		51.00
53.00	05300	ANESTHESIOLOGY	0	12,610		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	318,855		54.00
56.00	05600	RADIOISOTOPE	0	71,891		56.00
57.00	05700	CT SCAN	0	51,315		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	81,937		58.00
60.00	06000	LABORATORY	0	235,806		60.00
64.00	06400	INTRAVENOUS THERAPY	0	333,534		64.00
65.00	06500	RESPIRATORY THERAPY	0	191,326		65.00
66.00	06600	PHYSICAL THERAPY	0	187,292		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	40,858		67.00
68.00	06800	SPEECH PATHOLOGY	0	9,082		68.00
69.00	06900	ELECTROCARDIOLOGY	0	12,153		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	210,077		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	125,648		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	304,366		75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	55,089		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	483,935		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	60,386		101.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,742,786		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	15,763		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	864,018		192.00
194.00	07950	MARKETING	0	7,719		194.00
194.01	07951	FOUNDATION	0	9,642		194.01
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	5,639,928		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B-1 | Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	OFFSITE MOBS (MOB SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	99,957					1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	100				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			89,506			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	141	0	141	12,949,486		4.00
5.01	00540	BUSINESS OFFICE	1,330	0	1,330	269,266	-733,461	5.01
5.02	00541	DATA PROCESSING	1,553	0	1,553	286,326	0	5.02
5.03	00542	ADMITTING	820	0	820	236,555	0	5.03
5.04	00543	PURCHASING, RECEIVING AND STORES	364	0	364	52,693	0	5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL	19,467	0	19,467	571,094	0	5.05
7.00	00700	OPERATION OF PLANT	4,483	0	4,483	382,640	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	474	0	474	0	0	8.00
9.00	00900	HOUSEKEEPING	1,094	0	1,094	339,733	0	9.00
10.00	01000	DIETARY	2,721	0	2,721	81,676	0	10.00
11.00	01100	CAFETERIA	1,074	0	1,074	191,057	0	11.00
13.00	01300	NURSING ADMINISTRATION	355	0	355	149,881	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	887	0	887	227,230	0	16.00
17.00	01700	SOCIAL SERVICE	299	0	299	183,175	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,277	0	15,277	1,638,346	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,314	0	2,314	383,623	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,371	0	4,371	397,490	0	50.00
51.00	05100	RECOVERY ROOM	773	0	773	62,261	0	51.00
53.00	05300	ANESTHESIOLOGY	129	0	129	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,824	0	3,824	437,677	0	54.00
56.00	05600	RADIOISOTOPE	687	0	687	0	0	56.00
57.00	05700	CT SCAN	463	0	463	63,227	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,037	0	1,037	75,810	0	58.00
60.00	06000	LABORATORY	1,898	0	1,898	653,080	0	60.00
64.00	06400	INTRAVENOUS THERAPY	4,492	0	4,492	259,842	0	64.00
65.00	06500	RESPIRATORY THERAPY	2,165	0	2,165	472,497	0	65.00
66.00	06600	PHYSICAL THERAPY	2,171	0	2,171	391,188	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	414	0	414	126,378	0	67.00
68.00	06800	SPEECH PATHOLOGY	101	0	101	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	102	0	102	32,013	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,797	0	2,797	52,304	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	791	0	791	229,952	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,131	0	4,131	162,424	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	778	0	0	164,853	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	4,948	0	4,948	766,391	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	1,200	320,497	0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	88,725	0	89,147	9,661,179	-733,461	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	242	0	242	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	10,873	100	0	3,213,166	0	192.00
194.00	07950	MARKETING	59	0	59	24,807	0	194.00
194.01	07951	FOUNDATION	58	0	58	50,334	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,859,136	55,748	1,691,903	2,888,930		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	38.607961	557.480000	18.902677	0.223092		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				8,109		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000626		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B-1 | Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	BUSINESS OFFICE (ACCUM. COST)	DATA PROCESSING (MACHINE HOURS)	Reconciliation	ADMITTING (ACCUM. COST)	PURCHASING, RECEIVING AND STORES (COSTED REQUIS.)	
			5.01	5.02	5A.03	5.03	5.04	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	BUSINESS OFFICE	30,531,836					5.01
5.02	00541	DATA PROCESSING	949,970	285,193				5.02
5.03	00542	ADMITTING	387,978	7,920	-424,313	25,067,762		5.03
5.04	00543	PURCHASING, RECEIVING AND STORES	123,266	2,865	0	135,999	1,189,208	5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL	3,189,375	24,290	0	3,348,846	34,042	5.05
7.00	00700	OPERATION OF PLANT	1,331,232	64,152	0	1,582,037	19,071	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	98,055	0	0	100,411	0	8.00
9.00	00900	HOUSEKEEPING	529,167	25,885	0	630,173	18,503	9.00
10.00	01000	DIETARY	293,133	609	0	302,252	3,587	10.00
11.00	01100	CAFETERIA	314,249	1,423	0	326,652	0	11.00
13.00	01300	NURSING ADMINISTRATION	203,734	0	0	208,628	8,388	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	399,696	19,980	0	477,450	3,291	16.00
17.00	01700	SOCIAL SERVICE	243,333	2,115	0	256,393	1,328	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,063,263	32,720	0	3,248,460	104,974	30.00
31.00	03100	INTENSIVE CARE UNIT	655,260	3,837	0	684,089	5,180	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,205,068	10,962	0	1,271,408	227,141	50.00
51.00	05100	RECOVERY ROOM	161,808	0	0	165,695	0	51.00
53.00	05300	ANESTHESIOLOGY	75,705	0	0	77,524	40,973	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,148,126	1,796	0	1,181,833	8,650	54.00
56.00	05600	RADIOISOTOPE	503,484	5,539	0	534,472	1,554	56.00
57.00	05700	CT SCAN	371,384	3,733	0	393,039	1,047	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	230,742	2,307	0	244,154	2,346	58.00
60.00	06000	LABORATORY	1,692,460	9,115	0	1,764,209	409,748	60.00
64.00	06400	INTRAVENOUS THERAPY	616,301	0	0	631,106	28,937	64.00
65.00	06500	RESPIRATORY THERAPY	735,831	8,565	0	782,723	18,691	65.00
66.00	06600	PHYSICAL THERAPY	680,876	3,405	0	708,847	24,471	66.00
67.00	06700	OCCUPATIONAL THERAPY	192,310	1,830	0	203,172	9,125	67.00
68.00	06800	SPEECH PATHOLOGY	57,728	0	0	59,115	112	68.00
69.00	06900	ELECTROCARDIOLOGY	64,736	18	0	66,352	5,226	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	650,000	2,235	0	673,239	2,652	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,473,491	1,860	0	1,515,233	6,950	73.00
75.00	07500	ASC (NON-DISTINCT PART)	461,285	1,725	0	478,250	22,596	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	299,536	5,248	-324,633	0	6,260	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	2,231,127	15,940	0	2,339,096	81,111	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	493,075	3,545	0	517,012	4,844	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	25,126,784	263,619	-748,946	24,907,869	1,100,798	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	13,917	0	0	14,251	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,254,605	19,864	-5,448,589	0	85,559	192.00
194.00	07950	MARKETING	47,713	855	0	51,775	973	194.00
194.01	07951	FOUNDATION	88,817	855	0	93,867	1,878	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	733,461	972,791		424,313	138,301	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.024023	3.410992		0.016927	0.116297	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	76,659	91,878		50,833	22,476	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002511	0.322161		0.002028	0.018900	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B-1 | Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	
			5A.05	5.05	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	BUSINESS OFFICE						5.01
5.02	00541	DATA PROCESSING						5.02
5.03	00542	ADMITTING						5.03
5.04	00543	PURCHASING, RECEIVING AND STORES						5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL	-3,409,482	27,855,815				5.05
7.00	00700	OPERATION OF PLANT	0	1,611,034	71,799			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	102,111	474	123,908		8.00
9.00	00900	HOUSEKEEPING	0	642,992	1,094	0	4,123	9.00
10.00	01000	DIETARY	0	307,785	2,721	0	59	10.00
11.00	01100	CAFETERIA	0	332,181	1,074	0	119	11.00
13.00	01300	NURSING ADMINISTRATION	0	213,134	355	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	485,915	887	0	16	16.00
17.00	01700	SOCIAL SERVICE	0	260,887	299	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,315,655	15,277	40,253	1,178	30.00
31.00	03100	INTENSIVE CARE UNIT	0	696,271	2,314	4,072	99	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,319,345	4,371	14,143	220	50.00
51.00	05100	RECOVERY ROOM	0	168,500	773	0	39	51.00
53.00	05300	ANESTHESIOLOGY	0	83,601	129	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,202,844	3,824	7,609	165	54.00
56.00	05600	RADIOISOTOPE	0	543,700	687	1,367	30	56.00
57.00	05700	CT SCAN	0	399,814	463	921	20	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	248,560	1,037	2,063	45	58.00
60.00	06000	LABORATORY	0	1,841,726	1,898	0	114	60.00
64.00	06400	INTRAVENOUS THERAPY	0	645,154	4,492	418	137	64.00
65.00	06500	RESPIRATORY THERAPY	0	798,146	2,165	1,900	86	65.00
66.00	06600	PHYSICAL THERAPY	0	723,692	2,171	11,729	114	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	207,672	414	2,830	25	67.00
68.00	06800	SPEECH PATHOLOGY	0	60,129	101	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	68,083	102	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	684,943	2,797	151	32	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,541,689	791	0	47	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	488,973	4,131	5,153	207	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	325,361	778	507	63	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	2,388,123	4,948	28,872	383	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	526,326	0	0	46	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,409,482	22,234,346	60,567	121,988	3,244	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	14,492	242	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,458,539	10,873	1,920	879	192.00
194.00	07950	MARKETING	0	52,764	59	0	0	194.00
194.01	07951	FOUNDATION	0	95,674	58	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)		3,409,482	1,808,220	126,546	749,244	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.122397	25.184473	1.021290	181.723017	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		1,145,988	351,918	34,234	106,241	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.041140	4.901433	0.276286	25.767887	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B-1 | Date/Time Prepared: 8/26/2015 10:44 am

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540	BUSINESS OFFICE						5.01
5.02	00541	DATA PROCESSING						5.02
5.03	00542	ADMITTING						5.03
5.04	00543	PURCHASING, RECEIVING AND STORES						5.04
5.05	00560	OTHER ADMINISTRATIVE & GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	39,496					10.00
11.00	01100	CAFETERIA	27,668	162				11.00
13.00	01300	NURSING ADMINISTRATION	0	2	269,274			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	6	0	2,423		16.00
17.00	01700	SOCIAL SERVICE	0	3	0	0	921	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,407	36	137,389	924	806	30.00
31.00	03100	INTENSIVE CARE UNIT	501	6	24,005	3	30	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	7	18,094	0	0	50.00
51.00	05100	RECOVERY ROOM	0	1	2,232	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8	0	194	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	35	0	56.00
57.00	05700	CT SCAN	0	1	0	23	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1	0	53	0	58.00
60.00	06000	LABORATORY	0	14	0	28	0	60.00
64.00	06400	INTRAVENOUS THERAPY	125	6	11,853	245	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	9	0	47	0	65.00
66.00	06600	PHYSICAL THERAPY	0	7	0	41	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2	0	17	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1	1,267	28	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	557	4	8,813	149	44	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	2	0	20	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	238	15	46,518	340	38	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	17,934	0	3	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	39,496	136	268,105	2,148	921	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	24	1,169	275	0	192.00
194.00	07950	MARKETING	0	1	0	0	0	194.00
194.01	07951	FOUNDATION	0	1	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	424,706	719,031	257,038	597,268	313,664	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.753140	4,438.462963	0.954559	246.499381	340.568947	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	185,669	215,857	34,777	92,371	35,344	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.700957	1,332.450617	0.129151	38.122575	38.375679	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet C Part I Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,266,512		5,266,512	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	927,807		927,807	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,693,674		1,693,674	0	0	50.00
51.00	05100	RECOVERY ROOM	222,248		222,248	0	0	51.00
53.00	05300	ANESTHESIOLOGY	97,083		97,083	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,567,457		1,567,457	0	0	54.00
56.00	05600	RADIOISOTOPE	643,024		643,024	0	0	56.00
57.00	05700	CT SCAN	475,092		475,092	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	332,886		332,886	0	0	58.00
60.00	06000	LABORATORY	2,204,704		2,204,704	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	962,252		962,252	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,019,460	0	1,019,460	0	0	65.00
66.00	06600	PHYSICAL THERAPY	940,815	0	940,815	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	264,016	0	264,016	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	70,279	0	70,279	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	91,534		91,534	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	854,065		854,065	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,772,164		1,772,164	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	779,608		779,608	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	410,552		410,552	0	0	88.00
90.00	09000	CLINIC	0		0	0	0	90.00
91.00	09100	EMERGENCY	3,114,414		3,114,414	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,364,628		1,364,628		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	617,247		617,247		0	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	25,691,521	0	25,691,521	0	0	200.00
201.00		Less Observation Beds	1,364,628		1,364,628		0	201.00
202.00		Total (see instructions)	24,326,893	0	24,326,893	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet C Part I Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,182,306		3,182,306			30.00
31.00	03100	INTENSIVE CARE UNIT	326,643		326,643			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	815,106	3,168,675	3,983,781	0.425142	0.000000	50.00
51.00	05100	RECOVERY ROOM	103,278	298,143	401,421	0.553653	0.000000	51.00
53.00	05300	ANESTHESIOLOGY	228,908	918,711	1,147,619	0.084595	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	362,246	5,100,890	5,463,136	0.286915	0.000000	54.00
56.00	05600	RADIOISOTOPE	50,948	1,530,967	1,581,915	0.406485	0.000000	56.00
57.00	05700	CT SCAN	309,612	7,433,836	7,743,448	0.061354	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	119,503	2,309,664	2,429,167	0.137037	0.000000	58.00
60.00	06000	LABORATORY	881,753	8,556,136	9,437,889	0.233601	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	8,145	528,442	536,587	1.793282	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	595,015	507,796	1,102,811	0.924420	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	322,901	2,199,747	2,522,648	0.372947	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	136,387	413,354	549,741	0.480255	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	9,220	153,359	162,579	0.432276	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	59,392	1,842,466	1,901,858	0.048129	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,006,984	1,017,895	3,024,879	0.282347	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	819,848	4,324,377	5,144,225	0.344496	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	633,637	633,637	1.230370	0.000000	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	229,745	229,745			88.00
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
91.00	09100	EMERGENCY	48,818	5,788,368	5,837,186	0.533547	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	34,100	888,026	922,126	1.479872	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	583,561	583,561			101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	10,421,113	48,427,795	58,848,908			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	10,421,113	48,427,795	58,848,908			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet C Part I Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC (RHC)			88.00
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part II Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	362,000	3,983,781	0.090868	434,455	39,478	50.00
51.00	05100	RECOVERY ROOM	58,583	401,421	0.145939	57,134	8,338	51.00
53.00	05300	ANESTHESIOLOGY	12,610	1,147,619	0.010988	121,336	1,333	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	318,855	5,463,136	0.058365	246,721	14,400	54.00
56.00	05600	RADIOISOTOPE	71,891	1,581,915	0.045446	45,569	2,071	56.00
57.00	05700	CT SCAN	51,315	7,743,448	0.006627	197,597	1,309	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	81,937	2,429,167	0.033730	65,314	2,203	58.00
60.00	06000	LABORATORY	235,806	9,437,889	0.024985	514,988	12,867	60.00
64.00	06400	INTRAVENOUS THERAPY	333,534	536,587	0.621584	5,398	3,355	64.00
65.00	06500	RESPIRATORY THERAPY	191,326	1,102,811	0.173489	352,356	61,130	65.00
66.00	06600	PHYSICAL THERAPY	187,292	2,522,648	0.074244	64,978	4,824	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,858	549,741	0.074322	22,421	1,666	67.00
68.00	06800	SPEECH PATHOLOGY	9,082	162,579	0.055862	3,937	220	68.00
69.00	06900	ELECTROCARDIOLOGY	12,153	1,901,858	0.006390	52,977	339	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	210,077	3,024,879	0.069450	1,249,376	86,769	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	125,648	5,144,225	0.024425	406,698	9,934	73.00
75.00	07500	ASC (NON-DISTINCT PART)	304,366	633,637	0.480348	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	55,089	229,745	0.239783	0	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
91.00	09100	EMERGENCY	483,935	5,837,186	0.082906	87	7	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	495,185	922,126	0.537004	0	0	92.00
200.00		Total (lines 50-199)	3,641,542	54,756,398		3,841,342	250,243	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part IV | Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part IV Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,983,781	0.000000	0.000000	434,455	50.00
51.00	05100	RECOVERY ROOM	0	401,421	0.000000	0.000000	57,134	51.00
53.00	05300	ANESTHESIOLOGY	0	1,147,619	0.000000	0.000000	121,336	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,463,136	0.000000	0.000000	246,721	54.00
56.00	05600	RADIOISOTOPE	0	1,581,915	0.000000	0.000000	45,569	56.00
57.00	05700	CT SCAN	0	7,743,448	0.000000	0.000000	197,597	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	2,429,167	0.000000	0.000000	65,314	58.00
60.00	06000	LABORATORY	0	9,437,889	0.000000	0.000000	514,988	60.00
64.00	06400	INTRAVENOUS THERAPY	0	536,587	0.000000	0.000000	5,398	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,102,811	0.000000	0.000000	352,356	65.00
66.00	06600	PHYSICAL THERAPY	0	2,522,648	0.000000	0.000000	64,978	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	549,741	0.000000	0.000000	22,421	67.00
68.00	06800	SPEECH PATHOLOGY	0	162,579	0.000000	0.000000	3,937	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,901,858	0.000000	0.000000	52,977	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,024,879	0.000000	0.000000	1,249,376	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,144,225	0.000000	0.000000	406,698	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	633,637	0.000000	0.000000	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	229,745	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	5,837,186	0.000000	0.000000	87	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	922,126	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	54,756,398			3,841,342	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part IV | Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
57.00	05700	CT SCAN	0	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part V Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.425142	0	1,067,755	0	0	50.00
51.00	05100	RECOVERY ROOM	0.553653	0	101,003	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.084595	0	320,963	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286915	0	1,928,978	0	0	54.00
56.00	05600	RADIOISOTOPE	0.406485	0	770,039	0	0	56.00
57.00	05700	CT SCAN	0.061354	0	2,898,564	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.137037	0	810,486	0	0	58.00
60.00	06000	LABORATORY	0.233601	0	3,983,653	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1.793282	0	333,096	4,436	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.924420	0	212,874	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.372947	0	802,430	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.480255	0	134,309	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.432276	0	13,430	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048129	0	828,430	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.282347	0	408,018	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.344496	0	2,573,337	9,720	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.230370	0	262,155	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.533547	0	1,812,194	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.479872	0	693,761	0	0	92.00
200.00		Subtotal (see instructions)		0	19,955,475	14,156	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	19,955,475	14,156	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part V Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	453,947	0		50.00
51.00	05100	RECOVERY ROOM	55,921	0		51.00
53.00	05300	ANESTHESIOLOGY	27,152	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	553,453	0		54.00
56.00	05600	RADIOISOTOPE	313,009	0		56.00
57.00	05700	CT SCAN	177,838	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	111,067	0		58.00
60.00	06000	LABORATORY	930,585	0		60.00
64.00	06400	INTRAVENOUS THERAPY	597,335	7,955		64.00
65.00	06500	RESPIRATORY THERAPY	196,785	0		65.00
66.00	06600	PHYSICAL THERAPY	299,264	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	64,503	0		67.00
68.00	06800	SPEECH PATHOLOGY	5,805	0		68.00
69.00	06900	ELECTROCARDIOLOGY	39,872	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	115,203	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	886,504	3,349		73.00
75.00	07500	ASC (NON-DISTINCT PART)	322,548	0		75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	966,891	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,026,677	0		92.00
200.00		Subtotal (see instructions)	7,144,359	11,304		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	7,144,359	11,304		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141310 | Component CCN: 14Z310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part V | Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.425142	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.553653	0	0	0	0	51.00
53.00	05300	ANESTHESIOLOGY	0.084595	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286915	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.406485	0	0	0	0	56.00
57.00	05700	CT SCAN	0.061354	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.137037	0	0	0	0	58.00
60.00	06000	LABORATORY	0.233601	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1.793282	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.924420	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.372947	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.480255	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.432276	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048129	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.282347	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.344496	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.230370	0	0	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000				0	88.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.533547	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.479872	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141310 | Component CCN: 14Z310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part V | Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D-1 | Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,286	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,246	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,416	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	850	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	100	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	75	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	15	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	987	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	850	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	90	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	132.03	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.03	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,266,512	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	9,902	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,980	25.00
26.00	Total swing-bed cost (see instructions)	1,573,805	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,692,707	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,692,707	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,644.13	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,622,756	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,622,756	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D-1 | Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	927,807	136	6,822.11	102	695,855	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,324,855	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,643,466	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,397,511	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	147,972	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,545,483	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	830	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,644.13	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,364,628	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D-1 | Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,339,979	3,692,707	0.362872	1,364,628	495,185	90.00
91.00	Nursing School cost	0	3,692,707	0.000000	1,364,628	0	91.00
92.00	Allied health cost	0	3,692,707	0.000000	1,364,628	0	92.00
93.00	All other Medical Education	0	3,692,707	0.000000	1,364,628	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D-3 | Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,197,507		30.00
31.00	03100	INTENSIVE CARE UNIT		213,915		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.425142	434,455	184,705	50.00
51.00	05100	RECOVERY ROOM	0.553653	57,134	31,632	51.00
53.00	05300	ANESTHESIOLOGY	0.084595	121,336	10,264	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286915	246,721	70,788	54.00
56.00	05600	RADIOISOTOPE	0.406485	45,569	18,523	56.00
57.00	05700	CT SCAN	0.061354	197,597	12,123	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.137037	65,314	8,950	58.00
60.00	06000	LABORATORY	0.233601	514,988	120,302	60.00
64.00	06400	INTRAVENOUS THERAPY	1.793282	5,398	9,680	64.00
65.00	06500	RESPIRATORY THERAPY	0.924420	352,356	325,725	65.00
66.00	06600	PHYSICAL THERAPY	0.372947	64,978	24,233	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.480255	22,421	10,768	67.00
68.00	06800	SPEECH PATHOLOGY	0.432276	3,937	1,702	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048129	52,977	2,550	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.282347	1,249,376	352,758	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.344496	406,698	140,106	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.230370	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.533547	87	46	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.479872	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		3,841,342	1,324,855	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,841,342		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D-3

Component CCN: 14Z310 | Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.425142	16,030	6,815	50.00
51.00	05100	RECOVERY ROOM	0.553653	282	156	51.00
53.00	05300	ANESTHESIOLOGY	0.084595	2,496	211	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.286915	40,629	11,657	54.00
56.00	05600	RADIOISOTOPE	0.406485	3,154	1,282	56.00
57.00	05700	CT SCAN	0.061354	23,651	1,451	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.137037	6,330	867	58.00
60.00	06000	LABORATORY	0.233601	192,386	44,942	60.00
64.00	06400	INTRAVENOUS THERAPY	1.793282	2,743	4,919	64.00
65.00	06500	RESPIRATORY THERAPY	0.924420	143,675	132,816	65.00
66.00	06600	PHYSICAL THERAPY	0.372947	219,114	81,718	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.480255	96,595	46,390	67.00
68.00	06800	SPEECH PATHOLOGY	0.432276	4,929	2,131	68.00
69.00	06900	ELECTROCARDIOLOGY	0.048129	1,865	90	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.282347	259,236	73,195	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.344496	181,637	62,573	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.230370	0	0	75.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC (RHC)	0.000000		0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
91.00	09100	EMERGENCY	0.533547	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.479872	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,194,752	471,213	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,194,752		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141310	Period: From 04/01/2014 To 03/31/2015	Worksheet E Part B Date/Time Prepared: 8/26/2015 10:44 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,155,663	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,155,663	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	7,227,220	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	33,314	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	3,201,938	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	3,991,968	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,991,968	30.00
31.00	Primary payer payments	1,009	31.00
32.00	Subtotal (line 30 minus line 31)	3,990,959	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	490,918	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	373,098	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	403,957	36.00
37.00	Subtotal (see instructions)	4,364,057	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	4,364,057	40.00
40.01	Sequestration adjustment (see instructions)	87,281	40.01
41.00	Interim payments	4,275,185	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	1,591	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,554,285		4,651,229	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	10/22/2014	125,408		0	3.01
3.02		03/24/2015	783,387		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	10/22/2014	278,631	3.50
3.51			0	03/24/2015	97,413	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		908,795		-376,044	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,463,080		4,275,185	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		1,591	6.01
6.02	SETTLEMENT TO PROGRAM		116,499		0	6.02
7.00	Total Medicare program liability (see instructions)		3,346,581		4,276,776	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141310 | Component CCN: 14Z310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,731,114		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	10/22/2014	71,331		0	3.01
3.02		03/24/2015	223,016		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		294,347		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,025,461		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		34,686		0	6.02
7.00	Total Medicare program liability (see instructions)		1,990,775		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141310 | Component CCN: 14Z310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet E-2 | Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	1,560,938	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	475,925	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	940	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	2,036,863	0	8.00
9.00	Primary payer payments (see instructions)	57	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,036,806	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	2,036,806	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	5,403	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	2,031,403	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	2,031,403	0	19.00
19.01	Sequestration adjustment (see instructions)	40,628	0	19.01
20.00	Interim payments	2,025,461	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-34,686	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141310	Period: From 04/01/2014 To 03/31/2015	Worksheet E-3 Part V Date/Time Prepared: 8/26/2015 10:44 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,643,466	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,643,466	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,679,901	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,679,901	19.00
20.00	Deductibles (exclude professional component)	310,332	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,369,569	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,369,569	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	59,619	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	45,310	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	34,528	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,414,879	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	3,414,879	30.00
30.01	Sequestration adjustment (see instructions)	68,298	30.01
31.00	Interim payments	3,463,080	31.00
32.00	Tentative settlement (for contractor use only)	0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, and 32)	-116,499	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet G | Date/Time Prepared: 8/26/2015 10:44 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2,585,593	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,146,595	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,093,000	0	0	0	6.00
7.00	Inventory	644,448	0	0	0	7.00
8.00	Prepaid expenses	581,242	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,864,878	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	1,269,946	0	0	0	12.00
13.00	Land improvements	4,977,101	0	0	0	13.00
14.00	Accumulated depreciation	-1,236,548	0	0	0	14.00
15.00	Buildings	30,684,824	0	0	0	15.00
16.00	Accumulated depreciation	-5,915,313	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	4,252,078	0	0	0	19.00
20.00	Accumulated depreciation	-2,410,879	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	10,921,263	0	0	0	23.00
24.00	Accumulated depreciation	-8,800,989	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	33,741,483	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3,222,501	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	3,222,501	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	44,828,862	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,028,151	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,763,192	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,751,772	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	740,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,283,115	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	31,475,761	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	31,475,761	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	38,758,876	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	6,069,986				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	6,069,986	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	44,828,862	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet G-1 | Date/Time Prepared: 8/26/2015 10:44 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		9,050,378		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-2,980,392				2.00
3.00	Total (sum of line 1 and line 2)		6,069,986		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		6,069,986		0		11.00
12.00		0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		6,069,986		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/26/2015 10:44 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,195,276		2,195,276	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	940,519		940,519	5.00
6.00	Swing bed - NF	46,511		46,511	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,182,306		3,182,306	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	326,643		326,643	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	326,643		326,643	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,508,949		3,508,949	17.00
18.00	Ancillary services	6,829,246	40,938,095	47,767,341	18.00
19.00	Outpatient services	82,918	6,676,394	6,759,312	19.00
20.00	RURAL HEALTH CLINIC (RHC)	0	229,745	229,745	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		583,561	583,561	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PROFESSIONAL FEES	260,964	10,112,097	10,373,061	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,682,077	58,539,892	69,221,969	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		34,544,774		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		34,544,774		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet G-3 | Date/Time Prepared: 8/26/2015 10:44 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	69,221,969	1.00
2.00	Less contractual allowances and discounts on patients' accounts	38,515,697	2.00
3.00	Net patient revenues (line 1 minus line 2)	30,706,272	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	34,544,774	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-3,838,502	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	81,358	6.00
7.00	Income from investments	547,041	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	76	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	65,801	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	405	17.00
18.00	Revenue from sale of medical records and abstracts	12,348	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	1,652	21.00
22.00	Rental of hospital space	23,780	22.00
23.00	Governmental appropriations	0	23.00
24.00	GRANT INCOME	42,038	24.00
24.01	MEALS ON WHEELS INCOME	22,745	24.01
24.02	EHR MEANINGFUL USE INCOME	85,884	24.02
24.03	MEDICAID ADD ON PAYMENTS	38,870	24.03
24.04	OTHER INCOME	142,247	24.04
24.05	HPSA & OTHER PHYSICIAN INCOME	181,623	24.05
24.06	MISCELLANEOUS INCOME	15,326	24.06
24.07	UNREALIZED GAINS/LOSSES ON SECURITIE	-403,084	24.07
25.00	Total other income (sum of lines 6-24)	858,110	25.00
26.00	Total (line 5 plus line 25)	-2,980,392	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-2,980,392	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141310 | HHA CCN: 147616 | Period: From 04/01/2014 To 03/31/2015 | Worksheet H | Date/Time Prepared: 8/26/2015 10:44 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		8,712	8,712	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	5,191	5,191	3.00
4.00	Transportation	0	0	18,510	0	0	18,510	4.00
5.00	Administrative and General	112,059	0	0	0	14,133	126,192	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	187,682	0	0	0	0	187,682	6.00
7.00	Physical Therapy	0	0	0	31,736	0	31,736	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	708	0	708	9.00
10.00	Medical Social Services	102	0	0	0	0	102	10.00
11.00	Home Health Aide	3,739	0	0	0	0	3,739	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	179	179	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	303,582	0	18,510	32,444	28,215	382,751	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	8,712	0	8,712			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	5,191	0	5,191			3.00
4.00	Transportation	0	18,510	0	18,510			4.00
5.00	Administrative and General	-774	125,418	0	125,418			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	187,682	0	187,682			6.00
7.00	Physical Therapy	13,066	44,802	0	44,802			7.00
8.00	Occupational Therapy	3,849	3,849	0	3,849			8.00
9.00	Speech Pathology	0	708	0	708			9.00
10.00	Medical Social Services	0	102	0	102			10.00
11.00	Home Health Aide	0	3,739	0	3,739			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	179	0	179			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
24.00	Total (sum of lines 1-23)	16,141	398,892	0	398,892			24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 141310 HHA CCN: 147616 | Period: From 04/01/2014 To 03/31/2015 | Worksheet H-1 Part I Date/Time Prepared: 8/26/2015 10:44 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	8,712	8,712				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	5,191	0	0	5,191		0	3.00
4.00	Transportation	18,510	0	0	0	18,510		4.00
5.00	Administrative and General	125,418	8,712	0	5,191	0	139,321	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	187,682	0	0	0	11,572	199,254	6.00
7.00	Physical Therapy	44,802	0	0	0	4,805	49,607	7.00
8.00	Occupational Therapy	3,849	0	0	0	371	4,220	8.00
9.00	Speech Pathology	708	0	0	0	62	770	9.00
10.00	Medical Social Services	102	0	0	0	54	156	10.00
11.00	Home Health Aide	3,739	0	0	0	1,646	5,385	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	179	0	0	0		179	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	398,892	8,712	0	5,191	18,510	398,892	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	139,321		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	106,947	306,201	6.00
7.00	Physical Therapy	26,626	76,233	7.00
8.00	Occupational Therapy	2,265	6,485	8.00
9.00	Speech Pathology	413	1,183	9.00
10.00	Medical Social Services	84	240	10.00
11.00	Home Health Aide	2,890	8,275	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	96	275	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		398,892	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 141310 | HHA CCN: 147616 | Period: From 04/01/2014 To 03/31/2015 | Worksheet H-1 Part II | Date/Time Prepared: 8/26/2015 10:44 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	1,200				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	1,200		0		3.00
4.00	Transportation (see instructions)	0	0	0	2,396			4.00
5.00	Administrative and General	1,200	0	1,200	0	-139,321	259,571	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	1,498	0	199,254	6.00
7.00	Physical Therapy	0	0	0	622	0	49,607	7.00
8.00	Occupational Therapy	0	0	0	48	0	4,220	8.00
9.00	Speech Pathology	0	0	0	8	0	770	9.00
10.00	Medical Social Services	0	0	0	7	0	156	10.00
11.00	Home Health Aide	0	0	0	213	0	5,385	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	179	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,200	0	1,200	2,396	-139,321	259,571	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	8,712	0	5,191	18,510		139,321	25.00
26.00	Unit Cost Multiplier	7.260000	0.000000	4.325833	7.725376		0.536736	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141310 HHA CCN: 147616 | Period: From 04/01/2014 To 03/31/2015 | Worksheet H-2 Part I Date/Time Prepared: 8/26/2015 10:44 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	1.01	2.00	4.00	4A	
1.00	Administrative and General	0	0	0	22,683	24,999	47,682	1.00
2.00	Skilled Nursing Care	306,201	0	0	0	41,870	348,071	2.00
3.00	Physical Therapy	76,233	0	0	0	2,915	79,148	3.00
4.00	Occupational Therapy	6,485	0	0	0	859	7,344	4.00
5.00	Speech Pathology	1,183	0	0	0	0	1,183	5.00
6.00	Medical Social Services	240	0	0	0	23	263	6.00
7.00	Home Health Aide	8,275	0	0	0	834	9,109	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	275	0	0	0	0	275	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	398,892	0	0	22,683	71,500	493,075	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						0.000000	21.00

	Cost Center Description	BUSINESS OFFICE	DATA PROCESSING	Subtotal	ADMITTING	PURCHASING, RECEIVING AND STORES	Subtotal	
		5.01	5.02	5A.02	5.03	5.04	5A.04	
1.00	Administrative and General	1,145	12,092	60,919	1,031	563	62,513	1.00
2.00	Skilled Nursing Care	8,363	0	356,434	6,033	0	362,467	2.00
3.00	Physical Therapy	1,901	0	81,049	1,372	0	82,421	3.00
4.00	Occupational Therapy	176	0	7,520	127	0	7,647	4.00
5.00	Speech Pathology	28	0	1,211	20	0	1,231	5.00
6.00	Medical Social Services	6	0	269	5	0	274	6.00
7.00	Home Health Aide	219	0	9,328	158	0	9,486	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	7	0	282	5	0	287	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	11,845	12,092	517,012	8,751	563	526,326	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.000000			0.000000	21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141310 | HHA CCN: 147616 | Period: From 04/01/2014 To 03/31/2015 | Worksheet H-2 Part I | Date/Time Prepared: 8/26/2015 10:44 am

Home Health Agency I | PPS

	Cost Center Description	OTHER ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		5.05	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	7,651	0	0	8,359	0	0	1.00
2.00	Skilled Nursing Care	44,365	0	0	0	0	0	2.00
3.00	Physical Therapy	10,088	0	0	0	0	0	3.00
4.00	Occupational Therapy	936	0	0	0	0	0	4.00
5.00	Speech Pathology	151	0	0	0	0	0	5.00
6.00	Medical Social Services	34	0	0	0	0	0	6.00
7.00	Home Health Aide	1,161	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	35	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	64,421	0	0	8,359	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		13.00	16.00	17.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	1,022	79,545	0	79,545	1.00
2.00	Skilled Nursing Care	10,703	0	0	417,535	0	417,535	2.00
3.00	Physical Therapy	4,444	0	0	96,953	0	96,953	3.00
4.00	Occupational Therapy	343	0	0	8,926	0	8,926	4.00
5.00	Speech Pathology	57	0	0	1,439	0	1,439	5.00
6.00	Medical Social Services	50	0	0	358	0	358	6.00
7.00	Home Health Aide	1,522	0	0	12,169	0	12,169	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	322	0	322	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	17,119	0	1,022	617,247	0	617,247	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141310 | HHA CCN: 147616 | Period: From 04/01/2014 To 03/31/2015 | Worksheet H-2 Part I | Date/Time Prepared: 8/26/2015 10:44 am

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	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs			
		27.00	28.00			
1.00	Administrative and General					1.00
2.00	Skilled Nursing Care	61,768	479,303			2.00
3.00	Physical Therapy	14,343	111,296			3.00
4.00	Occupational Therapy	1,320	10,246			4.00
5.00	Speech Pathology	213	1,652			5.00
6.00	Medical Social Services	53	411			6.00
7.00	Home Health Aide	1,800	13,969			7.00
8.00	Supplies (see instructions)	0	0			8.00
9.00	Drugs	48	370			9.00
10.00	DME	0	0			10.00
11.00	Home Dialysis Aide Services	0	0			11.00
12.00	Respiratory Therapy	0	0			12.00
13.00	Private Duty Nursing	0	0			13.00
14.00	Clinic	0	0			14.00
15.00	Health Promotion Activities	0	0			15.00
16.00	Day Care Program	0	0			16.00
17.00	Home Delivered Meals Program	0	0			17.00
18.00	Homemaker Service	0	0			18.00
19.00	All Others (specify)	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	79,545	617,247			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.147935				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141310 HHA CCN: 147616 | Period: From 04/01/2014 To 03/31/2015 | Worksheet H-2 Part II Date/Time Prepared: 8/26/2015 10:44 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	OFFSITE MOBS (MOB SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	BUSINESS OFFICE (ACCUM. COST)	
		1.00	1.01	2.00	4.00	5A.01	5.01	
1.00	Administrative and General	0	0	1,200	112,059	0	47,682	1.00
2.00	Skilled Nursing Care	0	0	0	187,682	0	348,071	2.00
3.00	Physical Therapy	0	0	0	13,066	0	79,148	3.00
4.00	Occupational Therapy	0	0	0	3,849	0	7,344	4.00
5.00	Speech Pathology	0	0	0	0	0	1,183	5.00
6.00	Medical Social Services	0	0	0	102	0	263	6.00
7.00	Home Health Aide	0	0	0	3,739	0	9,109	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	275	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	1,200	320,497		493,075	20.00
21.00	Total cost to be allocated	0	0	22,683	71,500		11,845	21.00
22.00	Unit cost multiplier	0.000000	0.000000	18.902500	0.223091		0.024023	22.00

	Cost Center Description	DATA PROCESSING (MACHINE HOURS)	Reconciliation	ADMITTING (ACCUM. COST)	PURCHASING, RECEIVING AND STORES (COSTED REQUIS.)	Reconciliation	OTHER ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		5.02	5A.03	5.03	5.04	5A.05	5.05	
1.00	Administrative and General	3,545	0	60,919	4,844	0	62,513	1.00
2.00	Skilled Nursing Care	0	0	356,434	0	0	362,467	2.00
3.00	Physical Therapy	0	0	81,049	0	0	82,421	3.00
4.00	Occupational Therapy	0	0	7,520	0	0	7,647	4.00
5.00	Speech Pathology	0	0	1,211	0	0	1,231	5.00
6.00	Medical Social Services	0	0	269	0	0	274	6.00
7.00	Home Health Aide	0	0	9,328	0	0	9,486	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	282	0	0	287	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	3,545		517,012	4,844		526,326	20.00
21.00	Total cost to be allocated	12,092		8,751	563		64,421	21.00
22.00	Unit cost multiplier	3.411001		0.016926	0.116226		0.122398	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141310 HHA CCN: 147616

Period: From 04/01/2014 To 03/31/2015

Worksheet H-2 Part II Date/Time Prepared: 8/26/2015 10:44 am

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	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	46	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	11,213	2.00
3.00	Physical Therapy	0	0	0	0	0	4,656	3.00
4.00	Occupational Therapy	0	0	0	0	0	359	4.00
5.00	Speech Pathology	0	0	0	0	0	60	5.00
6.00	Medical Social Services	0	0	0	0	0	52	6.00
7.00	Home Health Aide	0	0	0	0	0	1,594	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	0	46	0	0	17,934	20.00
21.00	Total cost to be allocated	0	0	8,359	0	0	17,119	21.00
22.00	Unit cost multiplier	0.000000	0.000000	181.717391	0.000000	0.000000	0.954556	22.00

	Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)					
		16.00	17.00					
1.00	Administrative and General	0	3					1.00
2.00	Skilled Nursing Care	0	0					2.00
3.00	Physical Therapy	0	0					3.00
4.00	Occupational Therapy	0	0					4.00
5.00	Speech Pathology	0	0					5.00
6.00	Medical Social Services	0	0					6.00
7.00	Home Health Aide	0	0					7.00
8.00	Supplies (see instructions)	0	0					8.00
9.00	Drugs	0	0					9.00
10.00	DME	0	0					10.00
11.00	Home Dialysis Aide Services	0	0					11.00
12.00	Respiratory Therapy	0	0					12.00
13.00	Private Duty Nursing	0	0					13.00
14.00	Clinic	0	0					14.00
15.00	Health Promotion Activities	0	0					15.00
16.00	Day Care Program	0	0					16.00
17.00	Home Delivered Meals Program	0	0					17.00
18.00	Homemaker Service	0	0					18.00
19.00	All Others (specify)	0	0					19.00
20.00	Total (sum of lines 1-19)	0	3					20.00
21.00	Total cost to be allocated	0	1,022					21.00
22.00	Unit cost multiplier	0.000000	340.666667					22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141310 | HHA CCN: 147616 | Period: From 04/01/2014 To 03/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 8/26/2015 10:44 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	479,303		479,303	1,498	319.96	1.00
2.00	Physical Therapy	3.00	111,296	0	111,296	622	178.93	2.00
3.00	Occupational Therapy	4.00	10,246	0	10,246	48	213.46	3.00
4.00	Speech Pathology	5.00	1,652	0	1,652	8	206.50	4.00
5.00	Medical Social Services	6.00	411		411	7	58.71	5.00
6.00	Home Health Aide	7.00	13,969		13,969	213	65.58	6.00
7.00	Total (sum of lines 1-6)		616,877	0	616,877	2,396		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99914	0	1,347			8.00
9.00	Physical Therapy		99914	0	508			9.00
10.00	Occupational Therapy		99914	0	43			10.00
11.00	Speech Pathology		99914	0	6			11.00
12.00	Medical Social Services		99914	0	5			12.00
13.00	Home Health Aide		99914	0	194			13.00
14.00	Total (sum of lines 8-13)			0	2,103			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	10,853	10,853	38,440	0.282336	15.00
16.00	Cost of Drugs	9.00	370	0	370	378	0.978836	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,347		0	430,986		1.00
2.00	Physical Therapy	0	508		0	90,896		2.00
3.00	Occupational Therapy	0	43		0	9,179		3.00
4.00	Speech Pathology	0	6		0	1,239		4.00
5.00	Medical Social Services	0	5		0	294		5.00
6.00	Home Health Aide	0	194		0	12,723		6.00
7.00	Total (sum of lines 1-6)	0	2,103		0	545,317		7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141310 | HHA CCN: 147616 | Period: From 04/01/2014 To 03/31/2015 | Worksheet H-3 Part I | Date/Time Prepared: 8/26/2015 10:44 am

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	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	32,867	0				15.00
16.00	Cost of Drugs		360	0		352	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	430,986	1.00
2.00	Physical Therapy	90,896	2.00
3.00	Occupational Therapy	9,179	3.00
4.00	Speech Pathology	1,239	4.00
5.00	Medical Social Services	294	5.00
6.00	Home Health Aide	12,723	6.00
7.00	Total (sum of lines 1-6)	545,317	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 141310 HHA CCN: 147616 | Period: From 04/01/2014 To 03/31/2015 | Worksheet H-3 Part II Date/Time Prepared: 8/26/2015 10:44 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.372947	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.480255	0	0	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.432276	0	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.282347	38,440	10,853	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.344496	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet H-4 Part I-II

HHA CCN: 147616 | Date/Time Prepared: 8/26/2015 10:44 am

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	352	0	1.00
2.00	Total charges	0	360	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	360	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	8	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	1,544	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	-1,192	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	335,525	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	0	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	9,740	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	1,940	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	346,013	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	346,013	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	346,013	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	346,013	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	346,013	31.00
31.01	Sequestration adjustment (see instructions)	0	6,920	31.01
32.00	Interim payments (see instructions)	0	339,093	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	35.00

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

Provider CCN: 141310 HHA CCN: 147616 | Period: From 04/01/2014 To 03/31/2015 | Worksheet H-5 | Date/Time Prepared: 8/26/2015 10:44 am

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		339,093	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		339,093	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		339,093	7.00

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

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

Provider CCN: 141310 Component CCN: 148535 | Period: From 04/01/2014 To 03/31/2015 | Worksheet M-1 | Date/Time Prepared: 8/26/2015 10:44 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	61,539	0	61,539	0	61,539	1.00
2.00	Physician Assistant	16,485	0	16,485	0	16,485	2.00
3.00	Nurse Practitioner	10,590	0	10,590	0	10,590	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	39,233	0	39,233	0	39,233	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	127,847	0	127,847	0	127,847	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	127,847	0	127,847	0	127,847	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	37,006	67,869	104,875	0	104,875	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	37,006	67,869	104,875	0	104,875	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	164,853	67,869	232,722	0	232,722	32.00

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

Provider CCN: 141310 | Component CCN: 148535 | Period: From 04/01/2014 To 03/31/2015 | Worksheet M-1 | Date/Time Prepared: 8/26/2015 10:44 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	61,539		1.00
2.00	Physician Assistant	0	16,485		2.00
3.00	Nurse Practitioner	0	10,590		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	39,233		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	127,847		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	127,847		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	104,875		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	104,875		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	232,722		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141310 | Period: From 04/01/2014 To 03/31/2015 | Worksheet M-2

Component CCN: 148535 | Date/Time Prepared: 8/26/2015 10:44 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.38	938	4,200	1,596		1.00
2.00	Physician Assistant	0.20	466	2,100	420		2.00
3.00	Nurse Practitioner	0.13	155	2,100	273		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.71	1,559		2,289	2,289	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.71	1,559			2,289	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	127,847	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	127,847	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)	104,875	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	177,830	15.00
16.00	Total overhead (sum of lines 14 and 15)	282,705	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	282,705	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	282,705	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	410,552	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141310 Component CCN: 148535	Period: From 04/01/2014 To 03/31/2015	Worksheet M-3 Date/Time Prepared: 8/26/2015 10:44 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		410,552	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		410,552	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		2,289	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,289	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		179.36	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	179.36	179.36	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	0	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	0	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	16.00
16.01	Total program charges (see instructions)(from contractor's records)		0	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		0	16.04
16.05	Total program cost (see instructions)		0	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		0	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		0	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		0	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		0	26.00
26.01	Sequestration adjustment (see instructions)		0	26.01
27.00	Interim payments		0	27.00
28.00	Tentative settlement (for contractor use only)		0	28.00
29.00	Balance due component/program (line 26 minus lines 26.01, 27, and 28)		0	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00