

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 04/01/2015 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/25/2016 2:53 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 2/25/2016	Time: 2:53 pm
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 04/01/2015 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) _____
 Officer or Administrator of Provider(s)

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-27,262	66,128	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	35,679	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 I	0		182,927		0	10.00
200.00 Total	0	8,417	249,055	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141310		Period: From 04/01/2015 To 09/30/2015		Worksheet S-2 Part I Date/Time Prepared: 2/24/2016 4:59 pm							
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)					
				1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
								V	XVIII	XIX			
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										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)						04/01/2015	09/30/2015		20.00			
21.00	Type of Control (see instructions)						2		21.00				
Inpatient PPS Information													
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.						N	N		22.00			
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)						N	N		22.01			
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.						N	N		22.02			
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.						N	N		22.03			
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.						3		N	23.00			
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
				1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.						0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.						0	0	0	0	0	0	25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141310	Period: From 04/01/2015 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/24/2016 4:59 pm			
		Urban/Rural	S	Date of Geogr			
		1.00	2.00				
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2				26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2				27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0				35.00	
		Beginning:	Ending:				
		1.00	2.00				
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0				37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38.00	
		Y/N	Y/N				
		1.00	2.00				
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N			39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N			40.00	
		V	XVII	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, chapter 21, §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
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

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		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		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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	
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
<u>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.</u>							
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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	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

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		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
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	71.00
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				0	76.00
				1.00		
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N		81.00
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N		87.00
				V	XIX	
				1.00	2.00	
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00

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		V		XIX			
		1.00		2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N			96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00		97.00
Rural Providers							
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y					105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y					106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.	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	N	Y	N		109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.					N	110.00
						1.00	2.00
						3.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N			0		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N					116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	152,594	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141310	Period: From 04/01/2015 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/24/2016 4:59 pm		
		1.00	2.00			
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	149006	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: OSF HEALTHCARE SYSTEM	Contractor's Name: WPS		Contractor's Number: 00131		
142.00	Street: 800 N. E. GLEN OAK AVENUE	PO Box:				
143.00	City: PEORIA	State: 17	Zip Code: 61603	143.00		
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?	Y		144.00		
				1.00 2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00		
				1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	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	
156.00	Subprovider - IPF	N	N	N	N	
157.00	Subprovider - IRF	N	N	N	N	
158.00	SUBPROVIDER					
159.00	SNF	N	N	N	N	
160.00	HOME HEALTH AGENCY	N	N	N	N	
161.00	CMHC		N	N	N	
				1.00		
Multi campus						
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N		165.00		
		Name	County	State	Zip Code	CBSA
		0	1.00	2.00	3.00	4.00
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
				1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act						
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	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		
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			168.01		
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			0.00		
		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		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141310	Period: From 04/01/2015 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/24/2016 4:59 pm
			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 04/01/2015 To 09/30/2015	Worksheet S-2 Part II Date/Time Prepared: 2/24/2016 4:59 pm	
		Y/N	Date		
		1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
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	Type	Date	
		1.00	2.00	3.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
		Y/N		Legal Oper.	
		1.00		2.00	
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	01/29/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet S-2
Part II
Date/Time Prepared:
2/24/2016 4:59 pm

	Description	Part A		Part B		
		Y/N	Date	Y/N		
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 relieved 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
						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

		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)	01/29/2016	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 04/01/2015
To 09/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
2/24/2016 4:59 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits	Trips
	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	3,843	16,416.00	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	3,843	16,416.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	732	1,632.00	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	4,575	18,048.00	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	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 04/01/2015
To 09/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
2/24/2016 4:59 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	475	47	684			1.00
2.00 HMO and other (see instructions)	41	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	425	0	444			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	32			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	900	47	1,160			7.00
8.00 INTENSIVE CARE UNIT	44	0	68			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)	944	47	1,228	0.00	107.00	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	0	0	0	0.00	0.00	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	2,264	0	5,932	0.00	4.05	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	111.05	27.00
28.00 Observation Bed Days		0	389			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 04/01/2015
To 09/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
2/24/2016 4:59 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
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	178	20	275	1.00
2.00 HMO and other (see instructions)			19	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	178	20	275	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	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA		Provider CCN: 141310 Component CCN: 148535	Period: From 04/01/2015 To 09/30/2015	Worksheet S-8 Date/Time Prepared: 2/24/2016 4:59 pm		
			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	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	
					3.00	
					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 FOHC? 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						
		from	to	Monday	Tuesday	
		1.00	2.00	3.00	4.00	
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				Total Visits	
		Y/N	V	XVIII	XIX	
		1.00	2.00	3.00	4.00	
5.00						
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				15.00	
County						
4.00						
2.00	City, State, ZIP Code, County				LASALLE COUNTY	
2.00						
Tuesday						
		to	from	to	Thursday	
		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 04/01/2015 To 09/30/2015	Worksheet S-8 Date/Time Prepared: 2/24/2016 4:59 pm
			Rural Health Clinic (RHC) I	Cost
		Friday		Saturday
		from	to	from
		11.00	12.00	13.00
				14.00
11.00	Facility hours of operations (1) Clinic	08:00	17:00	
				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 141310	Period: From 04/01/2015 To 09/30/2015	Worksheet S-10 Date/Time Prepared: 2/24/2016 4:59 pm
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				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)		0.440556		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		265,370		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		478,842		5.00
6.00	Medicaid charges		4,955,432		6.00
7.00	Medicaid cost (line 1 times line 6)		2,183,145		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)		1,438,933		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)		1,438,933		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	690,595	35,797	726,392	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	304,246	15,771	320,017	21.00
22.00	Partial payment by patients approved for charity care	17,102	0	17,102	22.00
23.00	Cost of charity care (line 21 minus line 22)	287,144	15,771	302,915	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)		825,942		26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		251,779		27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		574,163		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		252,951		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		555,866		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,994,799		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141310

Period: From 04/01/2015 To 09/30/2015

Worksheet A
Date/Time Prepared: 2/24/2016 4:59 pm

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		1,666,209	1,666,209	1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS		0		23,231	23,231	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,287,101	1,287,101	-879,079	408,022	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	105,904	1,439,736	1,545,640	146,810	1,692,450	4.00
5.01	01140	BUSINESS OFFICE	109,579	118,985	228,564	71,921	300,485	5.01
5.02	00550	DATA PROCESSING	-1,960	294,824	292,864	1,749	294,613	5.02
5.03	00570	ADMINITTING	107,537	24,749	132,286	0	132,286	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	30,331	15,969	46,300	0	46,300	5.04
5.05	00590	OTHER A&G	583,060	1,304,032	1,887,092	-237,853	1,649,239	5.05
7.00	00700	OPERATION OF PLANT	156,176	283,294	439,470	740	440,210	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	32,987	32,987	0	32,987	8.00
9.00	00900	HOUSEKEEPING	158,276	28,422	186,698	0	186,698	9.00
10.00	01000	DIETARY	128,766	74,177	202,943	-141,371	61,572	10.00
11.00	01100	CAFETERIA	0	0	0	141,371	141,371	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	57,392	57,392	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	84,292	37,869	122,161	0	122,161	16.00
17.00	01700	SOCIAL SERVICE	90,108	607	90,715	0	90,715	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	775,623	69,655	845,278	0	845,278	30.00
31.00	03100	INTENSIVE CARE UNIT	143,029	29,437	172,466	0	172,466	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	217,075	340,441	557,516	-136,029	421,487	50.00
51.00	05100	RECOVERY ROOM	14,121	20,880	35,001	0	35,001	51.00
53.00	05300	ANESTHESIOLOGY	292,244	36,764	329,008	-5,364	323,644	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	296,208	596,431	892,639	-509,369	383,270	54.00
56.00	05600	RADIOISOTOPE	0	0	0	221,466	221,466	56.00
57.00	05700	CT SCAN	0	0	0	200,036	200,036	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	307	307	72,638	72,945	58.00
60.00	06000	LABORATORY	330,514	427,462	757,976	0	757,976	60.00
64.00	06400	INTRAVENOUS THERAPY	134,527	34,127	168,654	-19,987	148,667	64.00
65.00	06500	RESPIRATORY THERAPY	223,356	22,437	245,793	-6,518	239,275	65.00
66.00	06600	PHYSICAL THERAPY	178,063	52,613	230,676	0	230,676	66.00
67.00	06700	OCCUPATIONAL THERAPY	77,016	7,681	84,697	0	84,697	67.00
68.00	06800	SPEECH PATHOLOGY	0	26,762	26,762	0	26,762	68.00
69.00	06900	ELECTROCARDIOLOGY	15,865	61,521	77,386	0	77,386	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	21,561	56,481	78,042	137,391	215,433	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	130,483	571,466	701,949	45,736	747,685	73.00
75.00	07500	ASC (NON-DISTINCT PART)	82,384	13,894	96,278	0	96,278	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	848,484	34,769	883,253	-2,103	881,150	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	379,186	954,087	1,333,273	0	1,333,273	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	-1,042	10,489	9,447	-740	8,707	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		739,996	739,996	-739,996	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,710,766	9,050,452	14,761,218	108,281	14,869,499	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	23,753	23,753	0	23,753	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,437,702	162,958	1,600,660	-42,274	1,558,386	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	21,607	69,771	91,378	-66,007	25,371	194.01
194.02	07952	FOUNDATION	5,138	8,166	13,304	0	13,304	194.02
200.00		TOTAL (SUM OF LINES 118-199)	7,175,213	9,315,100	16,490,313	0	16,490,313	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet A
Date/Time Prepared:
2/24/2016 4:59 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	3,636	1,669,845	1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	23,231	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	672,506	1,080,528	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-40,209	1,652,241	4.00
5.01	01140	BUSINESS OFFICE	-49,223	251,262	5.01
5.02	00550	DATA PROCESSING	0	294,613	5.02
5.03	00570	ADMINITTING	0	132,286	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	0	46,300	5.04
5.05	00590	OTHER A&G	575,714	2,224,953	5.05
7.00	00700	OPERATION OF PLANT	0	440,210	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	32,987	8.00
9.00	00900	HOUSEKEEPING	0	186,698	9.00
10.00	01000	DIETARY	-5,719	55,853	10.00
11.00	01100	CAFETERIA	-47,900	93,471	11.00
13.00	01300	NURSING ADMINISTRATION	0	57,392	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,010	118,151	16.00
17.00	01700	SOCIAL SERVICE	0	90,715	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	845,278	30.00
31.00	03100	INTENSIVE CARE UNIT	0	172,466	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	421,487	50.00
51.00	05100	RECOVERY ROOM	0	35,001	51.00
53.00	05300	ANESTHESIOLOGY	-292,244	31,400	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	383,270	54.00
56.00	05600	RADIOISOTOPE	0	221,466	56.00
57.00	05700	CT SCAN	0	200,036	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	72,945	58.00
60.00	06000	LABORATORY	-6,548	751,428	60.00
64.00	06400	INTRAVENOUS THERAPY	0	148,667	64.00
65.00	06500	RESPIRATORY THERAPY	0	239,275	65.00
66.00	06600	PHYSICAL THERAPY	0	230,676	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	84,697	67.00
68.00	06800	SPEECH PATHOLOGY	0	26,762	68.00
69.00	06900	ELECTROCARDIOLOGY	-52,450	24,936	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	215,433	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	747,685	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	96,278	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	881,150	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	-423,308	909,965	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	-8,707	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	321,538	15,191,037	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	23,753	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,558,386	192.00
194.00	07950	OTHER NRCC	0	0	194.00
194.01	07951	MARKETING	0	25,371	194.01
194.02	07952	FOUNDATION	0	13,304	194.02
200.00		TOTAL (SUM OF LINES 118-199)	321,538	16,811,851	200.00

RECLASSIFICATIONS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet A-6
Date/Time Prepared:
2/24/2016 4:59 pm

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - TO RECLASS INTEREST EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00		699,258	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		30,123	2.00	
3.00	OTHER A&G	5.05		10,615	3.00	
	O		0	739,996		
B - TO RECLASS COPIER LEASE EXPENSE						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00		1,862	1.00	
	TOTALS		0	1,862		
C - TO RECLASS UTILITY EXPENSE						
1.00	OPERATION OF PLANT	7.00		740	1.00	
	TOTALS		0	740		
D - TO RECLASS CAFETERIA COSTS						
1.00	CAFETERIA	11.00	89,699	51,672	1.00	
	O		89,699	51,672		
E - TO RECLASS OFFSITE CLINIC EXPENSE						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00		40,593	1.00	
	O		0	40,593		
F - TO RECLASS BLDG DEPR EXPENSE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00		887,833	1.00	
2.00	CAP REL COSTS-OFFSITE MOBS	1.01		22,523	2.00	
	O		0	910,356		
G - TO RECLASS PHY CLNC OFF EQPMT DPR						
1.00	CAP REL COSTS-OFFSITE MOBS	1.01		708	1.00	
	O		0	708		
H - TO RECLASS PROPERTY INS EXP						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	79,118	1.00	
	O		0	79,118		
I - TO RECLASS WORKERS COMP						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		65,946	1.00	
	O		0	65,946		
J - TO RECLASS HR EXPENSES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	41,055	39,809	1.00	
	O		41,055	39,809		
K - TO RECLASS IMPLANTS AND O2 EXP						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00		141,011	1.00	
2.00					2.00	
	O		0	141,011		
L - TO RECLASS DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	45,736	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	
	O		0	45,736		
M - TO RECLASS CENTRAL BILL EXP						
1.00	BUSINESS OFFICE	5.01	25,203	46,718	1.00	
	O		25,203	46,718		
O - TO RECLASS NURSING ADMIN EXP						
1.00	NURSING ADMINISTRATION	13.00	56,777	615	1.00	
	O		56,777	615		
P - TO RECLASS ADVERTISING EXPENSE						
1.00	OTHER A&G	5.05		71,795	1.00	
2.00					2.00	
3.00					3.00	
	O		0	71,795		
S - TO RECLASS HHA SALARY TO OTHER						
1.00	HOME HEALTH AGENCY	101.00	1,042		1.00	
	TOTALS		1,042	0		
V - TO RECLASS PHYSICIAN ADMIN COSTS						
1.00	OTHER A&G	5.05	5,512		1.00	
	O		5,512	0		
W - TO RECLASS RADIOLOGY EXPENSES						
1.00	RADIOISOTOPE	56.00	0	221,466	1.00	
2.00	CT SCAN	57.00	70,693	129,343	2.00	
3.00	MAGNETIC RESONANCE IMAGING (MRI)	58.00	37,752	34,886	3.00	
	O		108,445	385,695		
X - TELEPHONE EXPENSE						
1.00	DATA PROCESSING	5.02	0	1,749	1.00	
2.00		0.00	0	0	2.00	
	O		0	1,749		
500.00	Grand Total: Increases		327,733	2,624,119	500.00	

RECLASSIFICATIONS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet A-6
Date/Time Prepared:
2/24/2016 4:59 pm

		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		739,996	11		1.00
2.00					11		2.00
3.00		0.00	0	0	0		3.00
	O		0	739,996			
B - TO RECLASS COPIER LEASE EXPENSE							
1.00	OTHER A&G	5.05		1,862	10		1.00
	TOTALS		0	1,862			
C - TO RECLASS UTILITY EXPENSE							
1.00	HOME HEALTH AGENCY	101.00		740	0		1.00
	TOTALS		0	740			
D - TO RECLASS CAFETERIA COSTS							
1.00	DIETARY	10.00	89,699	51,672	0		1.00
	O		89,699	51,672			
E - TO RECLASS OFFSITE CLINIC EXPENSE							
1.00	OTHER A&G	5.05		40,593	0		1.00
	O		0	40,593			
F - TO RECLASS BLDG DEPR EXPENSE							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00		910,356	9		1.00
2.00					9		2.00
	O		0	910,356			
G - TO RECLASS PHY CLNC OFF EQPMT DPR							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00		708	9		1.00
	O		0	708			
H - TO RECLASS PROPERTY INS EXP							
1.00	OTHER A&G	5.05	0	79,118	14		1.00
	O		0	79,118			
I - TO RECLASS WORKERS COMP							
1.00	OTHER A&G	5.05		65,946	0		1.00
	O		0	65,946			
J - TO RECLASS HR EXPENSES							
1.00	OTHER A&G	5.05	41,055	39,809	0		1.00
	O		41,055	39,809			
K - TO RECLASS IMPLANTS AND O2 EXP							
1.00	OPERATING ROOM	50.00		136,029	0		1.00
2.00	RESPIRATORY THERAPY	65.00		4,982	0		2.00
	O		0	141,011			
L - TO RECLASS DRUGS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	3,620	0		1.00
2.00	ANESTHESIOLOGY	53.00	0	5,364	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	15,229	0		3.00
4.00	RESPIRATORY THERAPY	65.00	0	1,536	0		4.00
5.00	INTRAVENOUS THERAPY	64.00	0	19,987	0		5.00
	O		0	45,736			
M - TO RECLASS CENTRAL BILL EXP							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	25,203	46,718	0		1.00
	O		25,203	46,718			
N - TO RECLASS NURSING ADMIN EXP							
1.00	OTHER A&G	5.05	56,777	615	0		1.00
	O		56,777	615			
P - TO RECLASS ADVERTISING EXPENSE							
1.00	RURAL HEALTH CLINIC	88.00		1,780	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00		4,008	0		2.00
3.00	MARKETING	194.01		66,007	0		3.00
	O		0	71,795			
S - TO RECLASS HHA SALARY TO OTHER							
1.00	HOME HEALTH AGENCY	101.00		1,042	0		1.00
	TOTALS		0	1,042			
V - TO RECLASS PHYSICIAN ADMIN COSTS							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	5,512	0	0		1.00
	O		5,512	0			
W - TO RECLASS RADIOLOGY EXPENSES							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	108,445	385,695	0		1.00
2.00					0		2.00
3.00					0		3.00
	O		108,445	385,695			
X - TELEPHONE EXPENSE							
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,426	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	323	0		2.00
	O		0	1,749			
500.00	Grand Total: Decreases		326,691	2,625,161			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet A-7
Part I
Date/Time Prepared:
2/24/2016 4:59 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,930,000	0	0	3,000	1.00
2.00	Land Improvements	2,096,452	0	0	0	2.00
3.00	Buildings and Fixtures	17,344,276	36,843	0	1,211,390	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	3,591,095	0	0	0	5.00
6.00	Movable Equipment	10,921,263	432,005	0	8,800	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,883,086	468,848	0	1,223,190	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,883,086	468,848	0	1,223,190	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,927,000	0			1.00
2.00	Land Improvements	2,096,452	0			2.00
3.00	Buildings and Fixtures	16,169,729	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	3,591,095	0			5.00
6.00	Movable Equipment	11,344,468	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	35,128,744	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	35,128,744	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet A-7
Part II
Date/Time Prepared:
2/24/2016 4:59 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	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	1,287,101	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,287,101	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	1,287,101				2.00
3.00	Total (sum of lines 1-2)	0	1,287,101				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet A-7
Part III
Date/Time Prepared:
2/24/2016 4:59 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	19,914,714	0	19,914,714	0.566907	0	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	278,468	0	278,468	0.007927	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	14,935,562	0	14,935,562	0.425166	0	2.00
3.00	Total (sum of lines 1-2)	35,128,744	0	35,128,744	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	939,587	-38,579	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	23,231	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,048,954	1,862	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,011,772	-36,717	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	689,719	0	0	79,118	1,669,845	1.00
1.01	CAP REL COSTS-OFFSITE MOBS	0	0	0	0	23,231	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	29,712	0	0	0	1,080,528	2.00
3.00	Total (sum of lines 1-2)	719,431	0	0	79,118	2,773,604	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet A-8

Date/Time Prepared:
2/24/2016 4:59 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-9,539	CAP REL COSTS-BLDG & FIXT	1.00	11 1.00
1.01 Investment income - CAP REL COSTS-OFFSITE MOBS (chapter 2)			OCAP REL COSTS-OFFSITE MOBS	1.01	0 1.01
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-411	CAP REL COSTS-MVBLE EQUIP	2.00	11 2.00
3.00 Investment income - other (chapter 2)	B	-145	OTHER A&G	5.05	0 3.00
4.00 Trade, quantity, and time discounts (chapter 8)	B	-513	OTHER A&G	5.05	0 4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-11,437	OTHER A&G	5.05	0 5.00
6.00 Rental of provider space by suppliers (chapter 8)	B	-38,579	CAP REL COSTS-BLDG & FIXT	1.00	10 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	-766,825			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	1,249,669			0 12.00
13.00 Laundry and linen service		0		0.00	0 13.00
14.00 Cafeteria-employees and guests	B	-35,612	CAFETERIA	11.00	0 14.00
15.00 Rental of quarters to employee and others		0		0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0 16.00
17.00 Sale of drugs to other than patients		0		0.00	0 17.00
18.00 Sale of medical records and abstracts	B	-4,010	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	-835	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	ORESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	OPHYSICAL 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	OCAP REL COSTS-BLDG & FIXT	1.00	0 26.00
26.01 Depreciation - CAP REL COSTS-OFFSITE MOBS		0	OCAP REL COSTS-OFFSITE MOBS	1.01	0 26.01
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	OCAP 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	OADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	OSPEECH PATHOLOGY	68.00	31.00

Provider CCN: 141310

Period:
 From 04/01/2015
 To 09/30/2015

Worksheet A-8

Date/Time Prepared:
 2/24/2016 4:59 pm

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.
			Cost Center	Line #	
			1.00	2.00	
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-107,599	CAP REL COSTS-MVBLE EQUIP	2.00	9 32.00
33.00 DIETARY REVENUE	B	-5,719	DIETARY	10.00	0 33.00
33.01 MEALS ON WHEELS	B	-11,453	CAFETERIA	11.00	0 33.01
33.02 AMBULANCE SUPPLY REVENUE	B	-7,725	EMERGENCY	91.00	0 33.02
33.03 LAB QUALITY CN REVENUE	B	-8,358	OTHER A&G	5.05	0 33.03
33.04 MISCELLANEOUS INCOME	B	-17,799	OTHER A&G	5.05	0 33.04
33.05 CABLE TV EXPENSE	A	-1,028	OTHER A&G	5.05	0 33.05
33.06 ADVERTISING EXPENSE	A	-17,579	OTHER A&G	5.05	0 33.06
33.07 COMMUNITY HEALTH EXPENSE	A	-54,454	OTHER A&G	5.05	0 33.07
33.08 COMMUNITY HEALTH BENEFIT EXPENSE	A	-9,065	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.08
33.09 LOBBYING EXPENSE	A	-6,485	OTHER A&G	5.05	0 33.09
33.10 CNRA BENEFIT EXPENSE	A	-27,683	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.10
33.11 PROVIDER TAX IDPA EXPENSE	A	-245,426	OTHER A&G	5.05	0 33.11
33.12 MERGER EXPENSES	A	-22,558	OTHER A&G	5.05	0 33.12
33.13 DEPRECIATION	A	544,097	CAP REL COSTS-MVBLE EQUIP	2.00	9 33.13
33.14 HOME HEALTH ELIMINATION	A	-8,707	HOME HEALTH AGENCY	101.00	0 33.14
33.15 CENTRAL BILLING OFFICE SALARIES	A	-17,249	BUSINESS OFFICE	5.01	0 33.15
33.16 CENTRAL BILLING OFFICE EXPENSES	A	-31,974	BUSINESS OFFICE	5.01	0 33.16
33.17 CENTRAL BILLING OFFICE BENEFITS	A	-3,461	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.17
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		321,538			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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet A-8-1

Date/Time Prepared:
2/24/2016 4:59 pm

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5		
1.00	2.00	3.00	4.00	5.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	1.00	CAP REL COSTS-BLDG & FIXT	CAPITAL BLDG HO BLDG CAPITA	51,754	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	CAPITAL MME HO MME CAPITAL	236,419	0	2.00
3.00	5.05	OTHER A&G	A&G HO MANAGEMENT	1,389,973	420,000	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	OSF SAINT ELI ZABETH	460	460	4.00
4.01	5.05	OTHER A&G	OSF SAINT ELI ZABETH	51,579	51,579	4.01
4.02	91.00	EMERGENCY	OSF SAINT ELI ZABETH	13,500	13,500	4.02
4.03	192.00	PHYSICIANS' PRIVATE OFFICES	OSF SAINT ELI ZABETH	1,200	1,200	4.03
4.04	192.00	PHYSICIANS' PRIVATE OFFICES	OSF HOME CARE SERVICES	7,220	7,220	4.04
4.05	5.05	OTHER A&G	MINISTRY SERVICES	0	8,477	4.05
4.06	4.00	EMPLOYEE BENEFITS DEPARTMENT	OSF SAINT FRANCIS MEDICAL CE	15,154	15,154	4.06
4.07	60.00	LABORATORY	OSF SAINT FRANCIS MEDICAL CE	77,296	77,296	4.07
4.08	91.00	EMERGENCY	OSF SAINT FRANCIS MEDICAL CE	500	500	4.08
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			1,845,055	595,386	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office	
			Name	Percentage of Ownership
1.00	2.00	3.00	4.00	5.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B		0.00	OSF HEALTHCARE	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet A-8-1

Date/Time Prepared:
2/24/2016 4:59 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	51,754	9		1.00
2.00	236,419	9		2.00
3.00	969,973	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
4.03	0	0		4.03
4.04	0	0		4.04
4.05	-8,477	0		4.05
4.06	0	0		4.06
4.07	0	0		4.07
4.08	0	0		4.08
5.00	1,249,669			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office	Type of Business	
	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOME OFFICE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet A-8-2

Date/Time Prepared:
2/24/2016 4:59 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	60.00	LABORATORY	12,500	6,548	5,952	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	52,450	52,450	0	0	0	2.00
3.00	91.00	EMERGENCY	867,323	415,583	451,740	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	292,244	292,244	0	0	0	4.00
5.00	5.05	OTHER A&G	5,512	0	5,512	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,230,029	766,825	463,204	0	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	5.05	OTHER A&G	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	60.00	LABORATORY	0	0	0	6,548	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	52,450	2.00
3.00	91.00	EMERGENCY	0	0	0	415,583	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	292,244	4.00
5.00	5.05	OTHER A&G	0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	766,825	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141310		Period: From 04/01/2015 To 09/30/2015		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/24/2016 4:59 pm	
		Physical Therapy		Cost			
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					6	1.00
2.00	Line 1 multiplied by 15 hours per week					90	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					70	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					5.70	7.00
8.00	Optional travel expense rate per mile					0.57	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	555.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.57	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)	39.29	39.29	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)					43,606	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					43,606	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)					43,606	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)					43,606	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)					2,750	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)					2,750	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)					399	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,149	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)					3,149	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					399	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 04/01/2015 To 09/30/2015		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/24/2016 4:59 pm	
								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	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	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)	78.57	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)							43,606	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							3,149	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)							46,755	63.00
64.00	Total cost of outside supplier services (from your records)							37,740	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							2,750	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							399	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							3,149	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							399	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							399	101.02
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others							0	102.01
102.02	Line 35 = sum of lines 31 and 32							0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141310		Period: From 04/01/2015 To 09/30/2015		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/24/2016 4:59 pm	
		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)					68	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					5.70	7.00
8.00	Optional travel expense rate per mile					0.57	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	435.50	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	71.57	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)	35.79	35.79	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					31,169	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					31,169	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)					31,169	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)					31,169	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)					2,434	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)					2,434	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)					388	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					2,822	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)					2,822	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					388	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 04/01/2015 To 09/30/2015		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 2/24/2016 4:59 pm	
						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	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	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)	71.57	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)							31,169	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))							2,822	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)							33,991	63.00
64.00	Total cost of outside supplier services (from your records)							26,639	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							2,434	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							388	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27							2,822	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							388	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							388	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 04/01/2015
To 09/30/2015

Worksheet B
Part I
Date/Time Prepared:
2/24/2016 4:59 pm

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP		
	0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,669,845	1,669,845			1.00
1.01 00101	CAP REL COSTS-OFFSITE MOBS	23,231	0	23,231		1.01
2.00 00200	CAP REL COSTS-MVBLE EQUIP	1,080,528			1,080,528	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,652,241		0	1,521	1,656,112 4.00
5.01 01140	BUSINESS OFFICE	251,262	22,165	0	14,342	33,416 5.01
5.02 00550	DATA PROCESSING	294,613	25,881	0	16,747	0 5.02
5.03 00570	ADMITTING	132,286	13,666	0	8,843	26,661 5.03
5.04 00560	PURCHASING RECEIVING AND STORES	46,300	6,066	0	3,925	7,520 5.04
5.05 00590	OTHER A&G	2,224,953	328,458	0	212,539	106,991 5.05
7.00 00700	OPERATION OF PLANT	440,210	74,710	0	48,344	38,720 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	32,987	7,899	0	5,112	0 8.00
9.00 00900	HOUSEKEEPING	186,698	18,232	0	11,797	39,241 9.00
10.00 01000	DIETARY	55,853	45,346	0	29,343	9,686 10.00
11.00 01100	CAFETERIA	93,471	17,899	0	11,582	22,239 11.00
13.00 01300	NURSING ADMINISTRATION	57,392	5,916	0	3,828	14,077 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	118,151	14,782	0	9,565	20,898 16.00
17.00 01700	SOCIAL SERVICE	90,715	4,983	0	3,224	22,340 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	845,278	254,596	0	164,744	192,299 30.00
31.00 03100	INTENSIVE CARE UNIT	172,466	38,563	0	24,954	35,461 31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	421,487	72,844	0	47,136	53,819 50.00
51.00 05100	RECOVERY ROOM	35,001	12,882	0	8,336	3,501 51.00
53.00 05300	ANESTHESIOLOGY	31,400	2,150	0	1,391	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	383,270	63,728	0	41,237	53,272 54.00
56.00 05600	RADIOISOTOPE	221,466	11,449	0	7,408	0 56.00
57.00 05700	CT SCAN	200,036	7,716	0	4,993	11,446 57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	72,945	17,282	0	11,183	8,721 58.00
60.00 06000	LABORATORY	751,428	31,631	0	20,468	81,944 60.00
64.00 06400	INTRAVENOUS THERAPY	148,667	74,860	0	48,441	33,353 64.00
65.00 06500	RESPIRATORY THERAPY	239,275	36,080	0	23,347	55,376 65.00
66.00 06600	PHYSICAL THERAPY	230,676	36,180	0	23,412	44,147 66.00
67.00 06700	OCCUPATIONAL THERAPY	84,697	6,899	0	4,465	19,094 67.00
68.00 06800	SPEECH PATHOLOGY	26,762	1,683	0	1,089	0 68.00
69.00 06900	ELECTROCARDIOLOGY	24,936	1,700	0	1,100	3,933 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	215,433	46,613	0	30,162	5,346 71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	747,685	13,182	0	8,530	32,350 73.00
75.00 07500	ASC (NON-DISTINCT PART)	96,278	68,844	0	44,548	20,425 75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	881,150	99,008	0	64,067	210,363 88.00
90.00 09000	CLINIC	0	0	0	0	0 90.00
91.00 09100	EMERGENCY	909,965	82,460	0	53,358	94,011 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	15,191,037	1,568,703	0	1,015,081	1,300,650 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	23,753	4,033	0	2,610	0 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	1,558,386	95,159	23,231	61,576	348,831 192.00
194.00 07950	OTHER NRCC	0	0	0	0	0 194.00
194.01 07951	MARKETING	25,371	983	0	636	5,357 194.01
194.02 07952	FOUNDATION	13,304	967	0	625	1,274 194.02
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	16,811,851	1,669,845	23,231	1,080,528	1,656,112 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141310

Period: From 04/01/2015 To 09/30/2015

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Cost Center Description			Subtotal	BUSINESS OFFICE	DATA PROCESSING	Subtotal	ADMINISTRATIVE	
			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	01140	BUSINESS OFFICE	321,185	321,185				5.01
5.02	00550	DATA PROCESSING	337,241	6,600	343,841			5.02
5.03	00570	ADMINISTRATIVE	181,456	3,551	2,203	187,210	187,210	5.03
5.04	00560	PURCHASING RECEIVING AND STORES	63,811	1,249	1,993	67,053	956	5.04
5.05	00590	OTHER A&G	2,872,941	56,231	18,669	2,947,841	42,023	5.05
7.00	00700	OPERATION OF PLANT	601,984	11,781	170,308	784,073	11,179	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,998	900	0	46,898	669	8.00
9.00	00900	HOUSEKEEPING	255,968	5,009	59,783	320,760	4,573	9.00
10.00	01000	DIETARY	140,228	2,744	3,246	146,218	2,085	10.00
11.00	01100	CAFETERIA	145,191	2,841	7,452	155,484	2,217	11.00
13.00	01300	NURSING ADMINISTRATION	81,213	1,589	0	82,802	1,181	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	163,396	3,198	787	167,381	2,386	16.00
17.00	01700	SOCIAL SERVICE	121,262	2,373	629	124,264	1,772	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,456,917	28,512	18,197	1,503,626	21,437	30.00
31.00	03100	INTENSIVE CARE UNIT	271,444	5,312	3,015	279,771	3,989	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	595,286	11,650	6,660	613,596	8,748	50.00
51.00	05100	RECOVERY ROOM	59,720	1,169	0	60,889	868	51.00
53.00	05300	ANESTHESIOLOGY	34,941	684	0	35,625	508	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	541,507	10,597	4,305	556,409	7,933	54.00
56.00	05600	RADIOISOTOPE	240,323	4,703	771	245,797	3,504	56.00
57.00	05700	CT SCAN	224,191	4,387	519	229,097	3,266	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	110,131	2,155	1,169	113,455	1,618	58.00
60.00	06000	LABORATORY	885,471	17,329	9,728	912,528	13,010	60.00
64.00	06400	INTRAVENOUS THERAPY	305,321	5,975	0	311,296	4,438	64.00
65.00	06500	RESPIRATORY THERAPY	354,078	6,929	3,120	364,127	5,191	65.00
66.00	06600	PHYSICAL THERAPY	334,415	6,545	2,439	343,399	4,896	66.00
67.00	06700	OCCUPATIONAL THERAPY	115,155	2,254	871	118,280	1,686	67.00
68.00	06800	SPEECH PATHOLOGY	29,534	578	0	30,112	429	68.00
69.00	06900	ELECTROCARDIOLOGY	31,669	620	891	33,180	473	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	297,554	5,823	472	303,849	4,332	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	801,747	15,690	1,311	818,748	11,673	73.00
75.00	07500	ASC (NON-DISTINCT PART)	230,095	4,503	5,401	239,999	3,422	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,254,588	24,552	4,667	1,283,807	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,139,794	22,306	12,638	1,174,738	16,748	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,645,755	280,339	341,244	14,602,312	187,210	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	30,396	0	0	30,396	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,087,183	40,846	1,967	2,129,996	0	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	32,347	0	315	32,662	0	194.01
194.02	07952	FOUNDATION	16,170	0	315	16,485	0	194.02
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	16,811,851	321,185	343,841	16,811,851	187,210	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141310

Period:
From 04/01/2015
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Cost Center Description			PURCHASING RECEIVING AND STORES	Subtotal	OTHER A&G	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	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMINITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES	68,009					5.04
5.05	00590	OTHER A&G	1,528	2,991,392	2,991,392			5.05
7.00	00700	OPERATION OF PLANT	830	796,082	172,310	968,392		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,567	10,296	6,393	64,256	8.00
9.00	00900	HOUSEKEEPING	1,180	326,513	70,673	14,755	0	9.00
10.00	01000	DIETARY	182	148,485	32,139	36,700	0	10.00
11.00	01100	CAFETERIA	418	158,119	34,224	14,486	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	83,983	18,178	4,788	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	207	169,974	36,790	11,963	0	16.00
17.00	01700	SOCIAL SERVICE	47	126,083	27,290	4,033	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	5,058	1,530,121	331,190	206,049	20,560	30.00
31.00	03100	INTENSIVE CARE UNIT	201	283,961	61,463	31,210	1,826	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,651	636,995	137,876	58,954	7,370	50.00
51.00	05100	RECOVERY ROOM	0	61,757	13,367	10,426	0	51.00
53.00	05300	ANESTHESIOLOGY	1,769	37,902	8,204	1,740	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	800	565,142	122,323	51,576	4,337	54.00
56.00	05600	RADIOISOTOPE	144	249,445	53,992	9,266	779	56.00
57.00	05700	CT SCAN	97	232,460	50,315	6,245	525	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	217	115,290	24,954	13,987	1,176	58.00
60.00	06000	LABORATORY	22,453	947,991	205,190	25,599	0	60.00
64.00	06400	INTRAVENOUS THERAPY	1,108	316,842	68,580	60,586	0	64.00
65.00	06500	RESPIRATORY THERAPY	985	370,303	80,151	29,201	1,125	65.00
66.00	06600	PHYSICAL THERAPY	1,309	349,604	75,671	29,281	6,907	66.00
67.00	06700	OCCUPATIONAL THERAPY	531	120,497	26,081	5,584	468	67.00
68.00	06800	SPEECH PATHOLOGY	14	30,555	6,614	1,362	0	68.00
69.00	06900	ELECTROCARDIOLOGY	245	33,898	7,337	1,376	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,375	310,556	67,219	37,725	78	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	255	830,676	179,797	10,669	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,406	244,827	52,992	55,717	3,028	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	2,179	1,285,986	278,348	80,129	187	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	5,728	1,197,214	259,133	66,736	15,015	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0				92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	65,917	14,600,220	2,512,697	886,536	63,381	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	30,396	6,579	3,264	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,940	2,131,936	461,446	77,014	875	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	151	32,813	7,102	796	0	194.01
194.02	07952	FOUNDATION	1	16,486	3,568	782	0	194.02
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	68,009	16,811,851	2,991,392	968,392	64,256	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

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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						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	01140						5.01
5.02	00550						5.02
5.03	00570						5.03
5.04	00560						5.04
5.05	00590						5.05
7.00	00700						7.00
8.00	00800						8.00
9.00	00900	411,941					9.00
10.00	01000	3,804	221,128				10.00
11.00	01100	8,727	0	215,556			11.00
13.00	01300	0	0	1,347	108,296		13.00
16.00	01600	2,461	0	6,736	0	227,924	16.00
17.00	01700	0	0	4,042	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	109,640	189,549	44,460	50,919	76,962	30.00
31.00	03100	10,964	12,477	6,736	6,970	185	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	19,243	0	9,431	10,837	0	50.00
51.00	05100	3,356	0	0	723	0	51.00
53.00	05300	0	0	4,042	0	0	53.00
54.00	05400	25,061	0	9,431	0	24,420	54.00
56.00	05600	4,475	0	0	0	4,440	56.00
57.00	05700	3,133	0	2,694	0	2,960	57.00
58.00	05800	6,713	0	1,347	0	6,660	58.00
60.00	06000	13,426	0	20,208	0	2,220	60.00
64.00	06400	15,216	0	8,083	9,387	0	64.00
65.00	06500	11,188	0	12,125	0	4,440	65.00
66.00	06600	14,544	0	8,083	0	1,850	66.00
67.00	06700	895	0	2,694	0	185	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	0	1,347	826	2,405	69.00
71.00	07100	3,133	0	0	0	0	71.00
73.00	07300	6,042	0	4,042	0	0	73.00
75.00	07500	18,125	11,977	5,389	5,584	14,245	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	45,871	2,157	26,945	0	24,050	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	41,172	4,968	20,208	22,258	31,636	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		367,189	221,128	199,390	107,504	196,658	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	44,752	0	14,819	792	31,266	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	1,347	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		411,941	221,128	215,556	108,296	227,924	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

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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	01140	BUSINESS OFFICE				5.01
5.02	00550	DATA PROCESSING				5.02
5.03	00570	ADMITTING				5.03
5.04	00560	PURCHASING RECEIVING AND STORES				5.04
5.05	00590	OTHER A&G				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	161,448			17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	145,135	2,704,585	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,856	421,648	0	31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	880,706	0	50.00
51.00	05100	RECOVERY ROOM	0	89,629	0	51.00
53.00	05300	ANESTHESIOLOGY	0	51,888	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	802,290	0	54.00
56.00	05600	RADIOISOTOPE	0	322,397	0	56.00
57.00	05700	CT SCAN	0	298,332	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	170,127	0	58.00
60.00	06000	LABORATORY	0	1,214,634	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	478,694	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	508,533	0	65.00
66.00	06600	PHYSICAL THERAPY	0	485,940	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	156,404	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	38,531	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	47,189	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	418,711	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,031,226	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,183	416,067	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,743,673	0	88.00
90.00	09000	CLINIC	0	0	0	90.00
91.00	09100	EMERGENCY	6,274	1,664,614	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	HOME HEALTH AGENCY	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	161,448	13,945,818	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	40,239	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,762,900	0	192.00
194.00	07950	OTHER NRCC	0	0	0	194.00
194.01	07951	MARKETING	0	42,058	0	194.01
194.02	07952	FOUNDATION	0	20,836	0	194.02
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	161,448	16,811,851	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

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Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS			Subtotal	
		BLDG & FIXT	OFFSITE MOBS	MVBLE EQUIP		
		0	1.00	1.01		
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	2,350	0	1,521	4.00
5.01 01140	BUSINESS OFFICE	0	22,165	0	14,342	5.01
5.02 00550	DATA PROCESSING	0	25,881	0	16,747	5.02
5.03 00570	ADMITTING	0	13,666	0	8,843	5.03
5.04 00560	PURCHASING RECEIVING AND STORES	0	6,066	0	3,925	5.04
5.05 00590	OTHER A&G	1,862	328,458	0	212,539	5.05
7.00 00700	OPERATION OF PLANT	0	74,710	0	48,344	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	7,899	0	5,112	8.00
9.00 00900	HOUSEKEEPING	0	18,232	0	11,797	9.00
10.00 01000	DIETARY	0	45,346	0	29,343	10.00
11.00 01100	CAFETERIA	0	17,899	0	11,582	11.00
13.00 01300	NURSING ADMINISTRATION	0	5,916	0	3,828	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	14,782	0	9,565	16.00
17.00 01700	SOCIAL SERVICE	0	4,983	0	3,224	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	254,596	0	164,744	30.00
31.00 03100	INTENSIVE CARE UNIT	0	38,563	0	24,954	31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	72,844	0	47,136	50.00
51.00 05100	RECOVERY ROOM	0	12,882	0	8,336	51.00
53.00 05300	ANESTHESIOLOGY	0	2,150	0	1,391	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	63,728	0	41,237	54.00
56.00 05600	RADIOISOTOPE	0	11,449	0	7,408	56.00
57.00 05700	CT SCAN	0	7,716	0	4,993	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	17,282	0	11,183	58.00
60.00 06000	LABORATORY	0	31,631	0	20,468	60.00
64.00 06400	INTRAVENOUS THERAPY	0	74,860	0	48,441	64.00
65.00 06500	RESPIRATORY THERAPY	0	36,080	0	23,347	65.00
66.00 06600	PHYSICAL THERAPY	0	36,180	0	23,412	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	6,899	0	4,465	67.00
68.00 06800	SPEECH PATHOLOGY	0	1,683	0	1,089	68.00
69.00 06900	ELECTROCARDIOLOGY	0	1,700	0	1,100	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	46,613	0	30,162	71.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	13,182	0	8,530	73.00
75.00 07500	ASC (NON-DISTINCT PART)	0	68,844	0	44,548	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	99,008	0	64,067	88.00
90.00 09000	CLINIC	0	0	0	0	90.00
91.00 09100	EMERGENCY	0	82,460	0	53,358	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,862	1,568,703	0	1,015,081	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	4,033	0	2,610	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	11,702	95,159	23,231	61,576	192.00
194.00 07950	OTHER NRCC	0	0	0	0	194.00
194.01 07951	MARKETING	0	983	0	636	194.01
194.02 07952	FOUNDATION	0	967	0	625	194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	13,564	1,669,845	23,231	1,080,528	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet B
Part II
Date/Time Prepared:
2/24/2016 4:59 pm

Cost Center Description			EMPLOYEE BENEFITS DEPARTMENT	BUSINESS OFFICE	DATA PROCESSING	ADMINITTING	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	3,871					4.00
5.01	01140	BUSINESS OFFICE	78	36,585				5.01
5.02	00550	DATA PROCESSING	0	752	43,380			5.02
5.03	00570	ADMINITTING	62	404	278	23,253		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	18	142	251	119	10,521	5.04
5.05	00590	OTHER A&G	250	6,406	2,355	5,220	236	5.05
7.00	00700	OPERATION OF PLANT	91	1,342	21,489	1,389	128	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	103	0	83	0	8.00
9.00	00900	HOUSEKEEPING	92	571	7,542	568	183	9.00
10.00	01000	DIETARY	23	313	410	259	28	10.00
11.00	01100	CAFETERIA	52	324	940	275	65	11.00
13.00	01300	NURSING ADMINISTRATION	33	181	0	147	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	49	364	99	296	32	16.00
17.00	01700	SOCIAL SERVICE	52	270	79	220	7	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	450	3,247	2,296	2,663	782	30.00
31.00	03100	INTENSIVE CARE UNIT	83	605	380	495	31	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	126	1,327	840	1,087	2,266	50.00
51.00	05100	RECOVERY ROOM	8	133	0	108	0	51.00
53.00	05300	ANESTHESIOLOGY	0	78	0	63	274	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	125	1,207	543	985	124	54.00
56.00	05600	RADIOISOTOPE	0	536	97	435	22	56.00
57.00	05700	CT SCAN	27	500	65	406	15	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	20	245	148	201	34	58.00
60.00	06000	LABORATORY	192	1,974	1,227	1,616	3,478	60.00
64.00	06400	INTRAVENOUS THERAPY	78	681	0	551	171	64.00
65.00	06500	RESPIRATORY THERAPY	130	789	394	645	152	65.00
66.00	06600	PHYSICAL THERAPY	103	745	308	608	202	66.00
67.00	06700	OCCUPATIONAL THERAPY	45	257	110	209	82	67.00
68.00	06800	SPEECH PATHOLOGY	0	66	0	53	2	68.00
69.00	06900	ELECTROCARDIOLOGY	9	71	112	59	38	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13	663	60	538	367	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76	1,787	165	1,450	39	73.00
75.00	07500	ASC (NON-DISTINCT PART)	48	513	681	425	217	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	492	2,796	589	0	337	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	220	2,541	1,594	2,080	886	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,045	31,933	43,052	23,253	10,198	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	810	4,652	248	0	300	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	13	0	40	0	23	194.01
194.02	07952	FOUNDATION	3	0	40	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,871	36,585	43,380	23,253	10,521	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet B
Part II
Date/Time Prepared:
2/24/2016 4:59 pm

Cost Center Description		OTHER A&G	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						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	01140						5.01
5.02	00550						5.02
5.03	00570						5.03
5.04	00560						5.04
5.05	00590	557,326					5.05
7.00	00700		179,596				7.00
8.00	00800	1,918	1,186	16,301			8.00
9.00	00900	13,167	2,737	0	54,889		9.00
10.00	01000	5,988	6,806	0	507	89,023	10.00
11.00	01100	6,376	2,686	0	1,163	0	11.00
13.00	01300	3,387	888	0	0	0	13.00
16.00	01600	6,854	2,219	0	328	0	16.00
17.00	01700	5,084	748	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	61,704	38,213	5,216	14,611	76,310	30.00
31.00	03100	11,451	5,788	463	1,461	5,023	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	25,687	10,933	1,870	2,564	0	50.00
51.00	05100	2,490	1,934	0	447	0	51.00
53.00	05300	1,528	323	0	0	0	53.00
54.00	05400	22,790	9,565	1,100	3,339	0	54.00
56.00	05600	10,059	1,718	198	596	0	56.00
57.00	05700	9,374	1,158	133	417	0	57.00
58.00	05800	4,649	2,594	298	894	0	58.00
60.00	06000	38,229	4,748	0	1,789	0	60.00
64.00	06400	12,777	11,236	0	2,027	0	64.00
65.00	06500	14,933	5,415	285	1,491	0	65.00
66.00	06600	14,098	5,430	1,752	1,938	0	66.00
67.00	06700	4,859	1,036	119	119	0	67.00
68.00	06800	1,232	253	0	0	0	68.00
69.00	06900	1,367	255	0	0	0	69.00
71.00	07100	12,523	6,996	20	417	0	71.00
73.00	07300	33,498	1,979	0	805	0	73.00
75.00	07500	9,873	10,333	768	2,415	4,822	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	51,859	14,861	48	6,112	868	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	48,279	12,377	3,809	5,486	2,000	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		468,136	164,415	16,079	48,926	89,023	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	1,226	605	0	0	0	190.00
192.00	19200	85,976	14,283	222	5,963	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	1,323	148	0	0	0	194.01
194.02	07952	665	145	0	0	0	194.02
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		557,326	179,596	16,301	54,889	89,023	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 141310		Period: From 04/01/2015 To 09/30/2015		Worksheet B Part II Date/Time Prepared: 2/24/2016 4:59 pm	
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	01140	BUSINESS OFFICE						5.01
5.02	00550	DATA PROCESSING						5.02
5.03	00570	ADMINITTING						5.03
5.04	00560	PURCHASING RECEIVING AND STORES						5.04
5.05	00590	OTHER A&G						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	41,362					11.00
13.00	01300	NURSING ADMINISTRATION	259	14,639				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,293	0	35,881			16.00
17.00	01700	SOCIAL SERVICE	776	0	0	15,443		17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,525	6,882	12,117	13,883	666,239	30.00
31.00	03100	INTENSIVE CARE UNIT	1,293	942	29	560	92,121	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,810	1,465	0	0	169,955	50.00
51.00	05100	RECOVERY ROOM	0	98	0	0	26,436	51.00
53.00	05300	ANESTHESIOLOGY	776	0	0	0	6,583	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,810	0	3,844	0	150,397	54.00
56.00	05600	RADIOISOTOPE	0	0	699	0	33,217	56.00
57.00	05700	CT SCAN	517	0	466	0	25,787	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	259	0	1,048	0	38,855	58.00
60.00	06000	LABORATORY	3,878	0	349	0	109,579	60.00
64.00	06400	INTRAVENOUS THERAPY	1,551	1,269	0	0	153,642	64.00
65.00	06500	RESPIRATORY THERAPY	2,327	0	699	0	86,687	65.00
66.00	06600	PHYSICAL THERAPY	1,551	0	291	0	86,618	66.00
67.00	06700	OCCUPATIONAL THERAPY	517	0	29	0	18,746	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	4,378	68.00
69.00	06900	ELECTROCARDIOLOGY	259	112	379	0	5,461	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	98,372	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	776	0	0	0	62,287	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,034	755	2,243	400	147,919	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	5,170	0	3,786	0	249,993	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	3,878	3,009	4,980	600	227,557	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	38,259	14,532	30,959	15,443	2,460,829	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	0	0	8,474	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,844	107	4,922	0	311,995	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	259	0	0	0	3,425	194.01
194.02	07952	FOUNDATION	0	0	0	0	2,445	194.02
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	41,362	14,639	35,881	15,443	2,787,168	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141310	Period: From 04/01/2015 To 09/30/2015	Worksheet B Part II Date/Time Prepared: 2/24/2016 4:59 pm
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	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	01140	BUSINESS OFFICE		5.01
5.02	00550	DATA PROCESSING		5.02
5.03	00570	ADMITTING		5.03
5.04	00560	PURCHASING RECEIVING AND STORES		5.04
5.05	00590	OTHER A&G		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	666,239
31.00	03100	INTENSIVE CARE UNIT	0	92,121
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	169,955
51.00	05100	RECOVERY ROOM	0	26,436
53.00	05300	ANESTHESIOLOGY	0	6,583
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	150,397
56.00	05600	RADIOISOTOPE	0	33,217
57.00	05700	CT SCAN	0	25,787
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	38,855
60.00	06000	LABORATORY	0	109,579
64.00	06400	INTRAVENOUS THERAPY	0	153,642
65.00	06500	RESPIRATORY THERAPY	0	86,687
66.00	06600	PHYSICAL THERAPY	0	86,618
67.00	06700	OCCUPATIONAL THERAPY	0	18,746
68.00	06800	SPEECH PATHOLOGY	0	4,378
69.00	06900	ELECTROCARDIOLOGY	0	5,461
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	98,372
73.00	07300	DRUGS CHARGED TO PATIENTS	0	62,287
75.00	07500	ASC (NON-DISTINCT PART)	0	147,919
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	249,993
90.00	09000	CLINIC	0	0
91.00	09100	EMERGENCY	0	227,557
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	
OTHER REIMBURSABLE COST CENTERS				
101.00	10100	HOME HEALTH AGENCY	0	0
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	2,460,829
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	8,474
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	311,995
194.00	07950	OTHER NRCC	0	0
194.01	07951	MARKETING	0	3,425
194.02	07952	FOUNDATION	0	2,445
200.00		Cross Foot Adjustments	0	0
201.00		Negative Cost Centers	0	0
202.00		TOTAL (sum lines 118-201)	0	2,787,168

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet B-1

Date/Time Prepared:
2/24/2016 4:59 pm

Cost Center Description		CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		BLDG & FIXT (SQUARE FEET)	OFFSITE MOBS (MOB SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)			
		1.00	1.01	2.00	4.00	5A.01	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	100,199				1.00
1.01	00101	CAP REL COSTS-OFFSITE MOBS	0	100			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			100,199		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	141	0	141	6,679,814	4.00
5.01	01140	BUSINESS OFFICE	1,330	0	1,330	134,782	-321,185
5.02	00550	DATA PROCESSING	1,553	0	1,553	0	0
5.03	00570	ADMITTING	820	0	820	107,537	0
5.04	00560	PURCHASING RECEIVING AND STORES	364	0	364	30,331	0
5.05	00590	OTHER A&G	19,709	0	19,709	431,542	0
7.00	00700	OPERATION OF PLANT	4,483	0	4,483	156,176	0
8.00	00800	LAUNDRY & LINEN SERVICE	474	0	474	0	0
9.00	00900	HOUSEKEEPING	1,094	0	1,094	158,276	0
10.00	01000	DIETARY	2,721	0	2,721	39,067	0
11.00	01100	CAFETERIA	1,074	0	1,074	89,699	0
13.00	01300	NURSING ADMINISTRATION	355	0	355	56,777	0
16.00	01600	MEDICAL RECORDS & LIBRARY	887	0	887	84,292	0
17.00	01700	SOCIAL SERVICE	299	0	299	90,108	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	15,277	0	15,277	775,623	0
31.00	03100	INTENSIVE CARE UNIT	2,314	0	2,314	143,029	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	4,371	0	4,371	217,075	0
51.00	05100	RECOVERY ROOM	773	0	773	14,121	0
53.00	05300	ANESTHESIOLOGY	129	0	129	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,824	0	3,824	214,869	0
56.00	05600	RADIOISOTOPE	687	0	687	0	0
57.00	05700	CT SCAN	463	0	463	46,165	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	1,037	0	1,037	35,174	0
60.00	06000	LABORATORY	1,898	0	1,898	330,514	0
64.00	06400	INTRAVENOUS THERAPY	4,492	0	4,492	134,527	0
65.00	06500	RESPIRATORY THERAPY	2,165	0	2,165	223,356	0
66.00	06600	PHYSICAL THERAPY	2,171	0	2,171	178,063	0
67.00	06700	OCCUPATIONAL THERAPY	414	0	414	77,016	0
68.00	06800	SPEECH PATHOLOGY	101	0	101	0	0
69.00	06900	ELECTROCARDIOLOGY	102	0	102	15,865	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,797	0	2,797	21,561	0
73.00	07300	DRUGS CHARGED TO PATIENTS	791	0	791	130,483	0
75.00	07500	ASC (NON-DISTINCT PART)	4,131	0	4,131	82,384	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	5,941	0	5,941	848,484	0
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	4,948	0	4,948	379,186	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	94,130	0	94,130	5,246,082	-321,185
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	242	0	242	0	-30,396
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,710	100	5,710	1,406,987	0
194.00	07950	OTHER NRCC	0	0	0	0	0
194.01	07951	MARKETING	59	0	59	21,607	-32,347
194.02	07952	FOUNDATION	58	0	58	5,138	-16,170
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,669,845	23,231	1,080,528	1,656,112	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.665286	232.310000	10.783820	0.247928	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				3,871	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000580	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet B-1

Date/Time Prepared:
2/24/2016 4:59 pm

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	01140	BUSINESS OFFICE	16,411,753					5.01
5.02	00550	DATA PROCESSING	337,241	65,567				5.02
5.03	00570	ADMITTING	181,456	420	-187,210	13,131,295		5.03
5.04	00560	PURCHASING RECEIVING AND STORES	63,811	380	0	67,053	600,942	5.04
5.05	00590	OTHER A&G	2,872,941	3,560	0	2,947,841	13,503	5.05
7.00	00700	OPERATION OF PLANT	601,984	32,476	0	784,073	7,333	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,998	0	0	46,898	0	8.00
9.00	00900	HOUSEKEEPING	255,968	11,400	0	320,760	10,431	9.00
10.00	01000	DIETARY	140,228	619	0	146,218	1,608	10.00
11.00	01100	CAFETERIA	145,191	1,421	0	155,484	3,693	11.00
13.00	01300	NURSING ADMINISTRATION	81,213	0	0	82,802	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	163,396	150	0	167,381	1,828	16.00
17.00	01700	SOCIAL SERVICE	121,262	120	0	124,264	414	17.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,456,917	3,470	0	1,503,626	44,691	30.00
31.00	03100	INTENSIVE CARE UNIT	271,444	575	0	279,771	1,773	31.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	595,286	1,270	0	613,596	129,455	50.00
51.00	05100	RECOVERY ROOM	59,720	0	0	60,889	0	51.00
53.00	05300	ANESTHESIOLOGY	34,941	0	0	35,625	15,635	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	541,507	821	0	556,409	7,067	54.00
56.00	05600	RADIOISOTOPE	240,323	147	0	245,797	1,270	56.00
57.00	05700	CT SCAN	224,191	99	0	229,097	856	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	110,131	223	0	113,455	1,916	58.00
60.00	06000	LABORATORY	885,471	1,855	0	912,528	198,401	60.00
64.00	06400	INTRAVENOUS THERAPY	305,321	0	0	311,296	9,794	64.00
65.00	06500	RESPIRATORY THERAPY	354,078	595	0	364,127	8,707	65.00
66.00	06600	PHYSICAL THERAPY	334,415	465	0	343,399	11,564	66.00
67.00	06700	OCCUPATIONAL THERAPY	115,155	166	0	118,280	4,688	67.00
68.00	06800	SPEECH PATHOLOGY	29,534	0	0	30,112	123	68.00
69.00	06900	ELECTROCARDIOLOGY	31,669	170	0	33,180	2,167	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	297,554	90	0	303,849	20,989	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	801,747	250	0	818,748	2,255	73.00
75.00	07500	ASC (NON-DISTINCT PART)	230,095	1,030	0	239,999	12,422	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	1,254,588	890	-1,283,807	0	19,252	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	1,139,794	2,410	0	1,174,738	50,616	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,324,570	65,072	-1,471,017	13,131,295	582,451	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	0	-30,396	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,087,183	375	-2,129,996	0	17,142	192.00
194.00	07950	OTHER NRCC	0	0	0	0	0	194.00
194.01	07951	MARKETING	0	60	-32,662	0	1,338	194.01
194.02	07952	FOUNDATION	0	60	-16,485	0	11	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	321,185	343,841		187,210	68,009	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.019570	5.244117		0.014257	0.113171	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,585	43,380		23,253	10,521	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002229	0.661613		0.001771	0.017508	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141310

Period: From 04/01/2015 To 09/30/2015

Worksheet B-1

Date/Time Prepared: 2/24/2016 4:59 pm

Cost Center Description		Reconciliation	OTHER A&G (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	01140	BUSINESS OFFICE					5.01
5.02	00550	DATA PROCESSING					5.02
5.03	00570	ADMINISTRATIVE					5.03
5.04	00560	PURCHASING RECEIVING AND STORES					5.04
5.05	00590	OTHER A&G	-2,991,392	13,820,459			5.05
7.00	00700	OPERATION OF PLANT	0	796,082	71,799		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	47,567	474	64,150	8.00
9.00	00900	HOUSEKEEPING	0	326,513	1,094	0	1,841
10.00	01000	DIETARY	0	148,485	2,721	0	17
11.00	01100	CAFETERIA	0	158,119	1,074	0	39
13.00	01300	NURSING ADMINISTRATION	0	83,983	355	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	169,974	887	0	11
17.00	01700	SOCIAL SERVICE	0	126,083	299	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,530,121	15,277	20,525	490
31.00	03100	INTENSIVE CARE UNIT	0	283,961	2,314	1,823	49
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	636,995	4,371	7,358	86
51.00	05100	RECOVERY ROOM	0	61,757	773	0	15
53.00	05300	ANESTHESIOLOGY	0	37,902	129	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	565,142	3,824	4,330	112
56.00	05600	RADIOISOTOPE	0	249,445	687	778	20
57.00	05700	CT SCAN	0	232,460	463	524	14
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	115,290	1,037	1,174	30
60.00	06000	LABORATORY	0	947,991	1,898	0	60
64.00	06400	INTRAVENOUS THERAPY	0	316,842	4,492	0	68
65.00	06500	RESPIRATORY THERAPY	0	370,303	2,165	1,123	50
66.00	06600	PHYSICAL THERAPY	0	349,604	2,171	6,896	65
67.00	06700	OCCUPATIONAL THERAPY	0	120,497	414	467	4
68.00	06800	SPEECH PATHOLOGY	0	30,555	101	0	0
69.00	06900	ELECTROCARDIOLOGY	0	33,898	102	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	310,556	2,797	78	14
73.00	07300	DRUGS CHARGED TO PATIENTS	0	830,676	791	0	27
75.00	07500	ASC (NON-DISTINCT PART)	0	244,827	4,131	3,023	81
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,285,986	5,941	187	205
90.00	09000	CLINIC	0	0	0	0	0
91.00	09100	EMERGENCY	0	1,197,214	4,948	14,990	184
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					
118.00		SUBTOTALS (SUM OF LINES 1-117)	-2,991,392	11,608,828	65,730	63,276	1,641
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP, & CANTEEN	0	30,396	242	0	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,131,936	5,710	874	200
194.00	07950	OTHER NRCC	0	0	0	0	0
194.01	07951	MARKETING	0	32,813	59	0	0
194.02	07952	FOUNDATION	0	16,486	58	0	0
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers					
202.00		Cost to be allocated (per Wkst. B, Part I)		2,991,392	968,392	64,256	411,941
203.00		Unit cost multiplier (Wkst. B, Part I)		0.216447	13.487542	1.001652	223.759370
204.00		Cost to be allocated (per Wkst. B, Part II)		557,326	179,596	16,301	54,889
205.00		Unit cost multiplier (Wkst. B, Part II)		0.040326	2.501372	0.254108	29.814775

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet B-1

Date/Time Prepared:
2/24/2016 4:59 pm

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						1.00
1.01	00101						1.01
2.00	00200						2.00
4.00	00400						4.00
5.01	01140						5.01
5.02	00550						5.02
5.03	00570						5.03
5.04	00560						5.04
5.05	00590						5.05
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	5,742					10.00
11.00	01100	0	160				11.00
13.00	01300	0	1	72,500			13.00
16.00	01600	0	5	0	1,232		16.00
17.00	01700	0	3	0	0	386	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,922	33	34,089	416	347	30.00
31.00	03100	324	5	4,666	1	14	31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	7	7,255	0	0	50.00
51.00	05100	0	0	484	0	0	51.00
53.00	05300	0	3	0	0	0	53.00
54.00	05400	0	7	0	132	0	54.00
56.00	05600	0	0	0	24	0	56.00
57.00	05700	0	2	0	16	0	57.00
58.00	05800	0	1	0	36	0	58.00
60.00	06000	0	15	0	12	0	60.00
64.00	06400	0	6	6,284	0	0	64.00
65.00	06500	0	9	0	24	0	65.00
66.00	06600	0	6	0	10	0	66.00
67.00	06700	0	2	0	1	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	1	553	13	0	69.00
71.00	07100	0	0	0	0	0	71.00
73.00	07300	0	3	0	0	0	73.00
75.00	07500	311	4	3,738	77	10	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	56	20	0	130	0	88.00
90.00	09000	0	0	0	0	0	90.00
91.00	09100	129	15	14,901	171	15	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		5,742	148	71,970	1,063	386	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
192.00	19200	0	11	530	169	0	192.00
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	1	0	0	0	194.01
194.02	07952	0	0	0	0	0	194.02
200.00							200.00
201.00							201.00
202.00		221,128	215,556	108,296	227,924	161,448	202.00
203.00		38.510623	1,347.225000	1.493738	185.003247	418.259067	203.00
204.00		89,023	41,362	14,639	35,881	15,443	204.00
205.00		15.503831	258.512500	0.201917	29.124188	40.007772	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet C
Part I
Date/Time Prepared:
2/24/2016 4:59 pm

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2,704,585		2,704,585	0	0 30.00
31.00	03100 INTENSIVE CARE UNIT	421,648		421,648	0	0 31.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	880,706		880,706	0	0 50.00
51.00	05100 RECOVERY ROOM	89,629		89,629	0	0 51.00
53.00	05300 ANESTHESIOLOGY	51,888		51,888	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	802,290		802,290	0	0 54.00
56.00	05600 RADIOISOTOPE	322,397		322,397	0	0 56.00
57.00	05700 CT SCAN	298,332		298,332	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	170,127		170,127	0	0 58.00
60.00	06000 LABORATORY	1,214,634		1,214,634	0	0 60.00
64.00	06400 INTRAVENOUS THERAPY	478,694		478,694	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	508,533	0	508,533	0	0 65.00
66.00	06600 PHYSICAL THERAPY	485,940	0	485,940	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	156,404	0	156,404	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	38,531	0	38,531	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	47,189		47,189	0	0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	418,711		418,711	0	0 71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,031,226		1,031,226	0	0 73.00
75.00	07500 ASC (NON-DISTINCT PART)	416,067		416,067	0	0 75.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	1,743,673		1,743,673	0	0 88.00
90.00	09000 CLINIC	0		0	0	0 90.00
91.00	09100 EMERGENCY	1,664,614		1,664,614	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	692,346		692,346	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0		0		0 101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	14,638,164	0	14,638,164	0	0 200.00
201.00	Less Observation Beds	692,346		692,346		0 201.00
202.00	Total (see instructions)	13,945,818	0	13,945,818	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet C
Part I
Date/Time Prepared:
2/24/2016 4:59 pm

		Title XVIII			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	1,515,042		1,515,042		30.00
31.00	03100	INTENSIVE CARE UNIT	173,144		173,144		31.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	448,486	1,594,938	2,043,424	0.430995	50.00
51.00	05100	RECOVERY ROOM	50,806	177,711	228,517	0.392220	51.00
53.00	05300	ANESTHESIOLOGY	121,220	486,144	607,364	0.085431	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	184,608	2,648,889	2,833,497	0.283145	54.00
56.00	05600	RADIOISOTOPE	65,648	746,383	812,031	0.397025	56.00
57.00	05700	CT SCAN	123,860	4,282,688	4,406,548	0.067702	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	57,188	1,224,903	1,282,091	0.132695	58.00
60.00	06000	LABORATORY	447,285	4,571,315	5,018,600	0.242026	60.00
64.00	06400	INTRAVENOUS THERAPY	150	351,300	351,450	1.362054	64.00
65.00	06500	RESPIRATORY THERAPY	266,367	249,333	515,700	0.986102	65.00
66.00	06600	PHYSICAL THERAPY	151,154	1,188,674	1,339,828	0.362688	66.00
67.00	06700	OCCUPATIONAL THERAPY	39,716	261,481	301,197	0.519275	67.00
68.00	06800	SPEECH PATHOLOGY	2,508	89,581	92,089	0.418410	68.00
69.00	06900	ELECTROCARDIOLOGY	30,328	1,009,671	1,039,999	0.045374	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	819,375	399,820	1,219,195	0.343432	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	449,787	2,254,073	2,703,860	0.381390	73.00
75.00	07500	ASC (NON-DISTINCT PART)	280	441,345	441,625	0.942127	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	1,044,243	1,044,243		88.00
90.00	09000	CLINIC	0	0	0	0.000000	90.00
91.00	09100	EMERGENCY	21,991	3,207,377	3,229,368	0.515461	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	456,233	456,233	1.517527	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	4,968,943	26,686,102	31,655,045		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	4,968,943	26,686,102	31,655,045		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet C
Part I
Date/Time Prepared:
2/24/2016 4:59 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	Cost
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
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				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 04/01/2015 To 09/30/2015	Worksheet D Part II Date/Time Prepared: 2/24/2016 4:59 pm
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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	169,955	2,043,424	0.083172	274,111	22,798	50.00
51.00	05100 RECOVERY ROOM	26,436	228,517	0.115685	33,723	3,901	51.00
53.00	05300 ANESTHESIOLOGY	6,583	607,364	0.010839	72,100	781	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	150,397	2,833,497	0.053078	127,928	6,790	54.00
56.00	05600 RADIOISOTOPE	33,217	812,031	0.040906	38,500	1,575	56.00
57.00	05700 CT SCAN	25,787	4,406,548	0.005852	83,417	488	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	38,855	1,282,091	0.030306	30,303	918	58.00
60.00	06000 LABORATORY	109,579	5,018,600	0.021835	261,154	5,702	60.00
64.00	06400 INTRAVENOUS THERAPY	153,642	351,450	0.437166	150	66	64.00
65.00	06500 RESPIRATORY THERAPY	86,687	515,700	0.168096	141,326	23,756	65.00
66.00	06600 PHYSICAL THERAPY	86,618	1,339,828	0.064649	31,359	2,027	66.00
67.00	06700 OCCUPATIONAL THERAPY	18,746	301,197	0.062238	6,384	397	67.00
68.00	06800 SPEECH PATHOLOGY	4,378	92,089	0.047541	1,308	62	68.00
69.00	06900 ELECTROCARDIOLOGY	5,461	1,039,999	0.005251	23,700	124	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	98,372	1,219,195	0.080686	558,037	45,026	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	62,287	2,703,860	0.023036	225,055	5,184	73.00
75.00	07500 ASC (NON-DISTINCT PART)	147,919	441,625	0.334943	160	54	75.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	249,993	1,044,243	0.239401	0	0	88.00
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
91.00	09100 EMERGENCY	227,557	3,229,368	0.070465	85	6	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	241,535	456,233	0.529412	0	0	92.00
200.00	Total (lines 50-199)	1,944,004	29,966,859		1,908,800	119,655	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet D
Part IV
Date/Time Prepared:
2/24/2016 4:59 pm

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	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 04/01/2015
To 09/30/2015

Worksheet D
Part IV
Date/Time Prepared:
2/24/2016 4:59 pm

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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Cost		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,043,424	0.000000	0.000000	274,111	50.00
51.00	05100	RECOVERY ROOM	0	228,517	0.000000	0.000000	33,723	51.00
53.00	05300	ANESTHESIOLOGY	0	607,364	0.000000	0.000000	72,100	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,833,497	0.000000	0.000000	127,928	54.00
56.00	05600	RADIOISOTOPE	0	812,031	0.000000	0.000000	38,500	56.00
57.00	05700	CT SCAN	0	4,406,548	0.000000	0.000000	83,417	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	1,282,091	0.000000	0.000000	30,303	58.00
60.00	06000	LABORATORY	0	5,018,600	0.000000	0.000000	261,154	60.00
64.00	06400	INTRAVENOUS THERAPY	0	351,450	0.000000	0.000000	150	64.00
65.00	06500	RESPIRATORY THERAPY	0	515,700	0.000000	0.000000	141,326	65.00
66.00	06600	PHYSICAL THERAPY	0	1,339,828	0.000000	0.000000	31,359	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	301,197	0.000000	0.000000	6,384	67.00
68.00	06800	SPEECH PATHOLOGY	0	92,089	0.000000	0.000000	1,308	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,039,999	0.000000	0.000000	23,700	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,219,195	0.000000	0.000000	558,037	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,703,860	0.000000	0.000000	225,055	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	441,625	0.000000	0.000000	160	75.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	1,044,243	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	3,229,368	0.000000	0.000000	85	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	456,233	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	29,966,859			1,908,800	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet D
Part IV
Date/Time Prepared:
2/24/2016 4:59 pm

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)	Cost
		11.00	12.00	13.00	
Title XVIII Hospital Cost					
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	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 04/01/2015 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 2/24/2016 4:59 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.430995	0	374,335	0	0
51.00 05100 RECOVERY ROOM	0.392220	0	66,198	0	0
53.00 05300 ANESTHESIOLOGY	0.085431	0	180,733	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.283145	0	983,714	0	0
56.00 05600 RADIOISOTOPE	0.397025	0	402,208	0	0
57.00 05700 CT SCAN	0.067702	0	1,658,716	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.132695	0	496,018	0	0
60.00 06000 LABORATORY	0.242026	0	2,066,694	0	0
64.00 06400 INTRAVENOUS THERAPY	1.362054	0	157,698	15	0
65.00 06500 RESPIRATORY THERAPY	0.986102	0	116,087	0	0
66.00 06600 PHYSICAL THERAPY	0.362688	0	516,212	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.519275	0	28,933	0	0
68.00 06800 SPEECH PATHOLOGY	0.418410	0	2,691	0	0
69.00 06900 ELECTROCARDIOLOGY	0.045374	0	412,637	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.343432	0	96,463	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.381390	0	1,477,190	1,080	0
75.00 07500 ASC (NON-DISTINCT PART)	0.942127	0	441,345	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
90.00 09000 CLINIC	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.515461	0	958,121	573	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.517527	0	340,545	0	0
200.00 Subtotal (see instructions)		0	10,776,538	1,668	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	10,776,538	1,668	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141310	Period: From 04/01/2015 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 2/24/2016 4:59 pm
	Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	161,337	0		50.00
51.00 05100 RECOVERY ROOM	25,964	0		51.00
53.00 05300 ANESTHESIOLOGY	15,440	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	278,534	0		54.00
56.00 05600 RADIOISOTOPE	159,687	0		56.00
57.00 05700 CT SCAN	112,298	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	65,819	0		58.00
60.00 06000 LABORATORY	500,194	0		60.00
64.00 06400 INTRAVENOUS THERAPY	214,793	20		64.00
65.00 06500 RESPIRATORY THERAPY	114,474	0		65.00
66.00 06600 PHYSICAL THERAPY	187,224	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	15,024	0		67.00
68.00 06800 SPEECH PATHOLOGY	1,126	0		68.00
69.00 06900 ELECTROCARDIOLOGY	18,723	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	33,128	0		71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	563,385	412		73.00
75.00 07500 ASC (NON-DISTINCT PART)	415,803	0		75.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
90.00 09000 CLINIC	0	0		90.00
91.00 09100 EMERGENCY	493,874	295		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	516,786	0		92.00
200.00 Subtotal (see instructions)	3,893,613	727		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	3,893,613	727		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141310

Period: From 04/01/2015

Worksheet D

Component CCN: 14Z310

To 09/30/2015

Part V
Date/Time Prepared:
2/24/2016 4:59 pm

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
	1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0.430995	0	0	0	0
51.00 05100 RECOVERY ROOM	0.392220	0	0	0	0
53.00 05300 ANESTHESIOLOGY	0.085431	0	0	0	0
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.283145	0	0	0	0
56.00 05600 RADIOISOTOPE	0.397025	0	0	0	0
57.00 05700 CT SCAN	0.067702	0	0	0	0
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.132695	0	0	0	0
60.00 06000 LABORATORY	0.242026	0	0	0	0
64.00 06400 INTRAVENOUS THERAPY	1.362054	0	0	0	0
65.00 06500 RESPIRATORY THERAPY	0.986102	0	0	0	0
66.00 06600 PHYSICAL THERAPY	0.362688	0	0	0	0
67.00 06700 OCCUPATIONAL THERAPY	0.519275	0	0	0	0
68.00 06800 SPEECH PATHOLOGY	0.418410	0	0	0	0
69.00 06900 ELECTROCARDIOLOGY	0.045374	0	0	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.343432	0	0	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.381390	0	0	0	0
75.00 07500 ASC (NON-DISTINCT PART)	0.942127	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
90.00 09000 CLINIC	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.515461	0	0	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.517527	0	0	0	0
200.00 Subtotal (see instructions)		0	0	0	0
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	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141310

Period: From 04/01/2015

Worksheet D

Component CCN: 14Z310

To 09/30/2015

Part V
Date/Time Prepared:
2/24/2016 4:59 pm

Title XVIII

Swing Beds - SNF

Cost

Cost Center Description	Costs			Cost
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	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	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 04/01/2015 To 09/30/2015	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/24/2016 4:59 pm
Cost Center Description				Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,549	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,073	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)		684	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		444	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		32	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		475	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)		425	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			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		144.08	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		144.08	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,704,585	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)		4,611	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		794,847	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		1,909,738	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)		1,909,738	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)		1,779.81	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		845,410	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)		845,410	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141310		Period: From 04/01/2015 To 09/30/2015		Worksheet D-1	
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	421,648	68	6,200.71	44	272,831		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)					695,462		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,813,703		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)					756,419		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					756,419		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						389	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,779.81	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						692,346	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141310		Period: From 04/01/2015 To 09/30/2015		Worksheet D-1 Date/Time Prepared: 2/24/2016 4:59 pm	
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	666,239	1,909,738	0.348864	692,346	241,535	90.00
91.00	Nursing School cost	0	1,909,738	0.000000	692,346	0	91.00
92.00	Allied health cost	0	1,909,738	0.000000	692,346	0	92.00
93.00	All other Medical Education	0	1,909,738	0.000000	692,346	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141310	Period: From 04/01/2015 To 09/30/2015	Worksheet D-3 Date/Time Prepared: 2/24/2016 4:59 pm	
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		558,792		30.00
31.00	03100 INTENSIVE CARE UNIT		100,388		31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.430995	274,111	118,140	50.00
51.00	05100 RECOVERY ROOM	0.392220	33,723	13,227	51.00
53.00	05300 ANESTHESIOLOGY	0.085431	72,100	6,160	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.283145	127,928	36,222	54.00
56.00	05600 RADIOISOTOPE	0.397025	38,500	15,285	56.00
57.00	05700 CT SCAN	0.067702	83,417	5,647	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.132695	30,303	4,021	58.00
60.00	06000 LABORATORY	0.242026	261,154	63,206	60.00
64.00	06400 INTRAVENOUS THERAPY	1.362054	150	204	64.00
65.00	06500 RESPIRATORY THERAPY	0.986102	141,326	139,362	65.00
66.00	06600 PHYSICAL THERAPY	0.362688	31,359	11,374	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.519275	6,384	3,315	67.00
68.00	06800 SPEECH PATHOLOGY	0.418410	1,308	547	68.00
69.00	06900 ELECTROCARDIOLOGY	0.045374	23,700	1,075	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.343432	558,037	191,648	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.381390	225,055	85,834	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0.942127	160	151	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.000000	0	0	90.00
91.00	09100 EMERGENCY	0.515461	85	44	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.517527	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,908,800	695,462	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)		1,908,800		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141310	Period: From 04/01/2015 To 09/30/2015	Worksheet D-3	
		Component CCN: 14Z310		Date/Time Prepared: 2/24/2016 4:59 pm	
		Title XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.430995	3,541	50.00
51.00	05100	RECOVERY ROOM	0.392220	115	51.00
53.00	05300	ANESTHESIOLOGY	0.085431	1,108	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.283145	22,064	54.00
56.00	05600	RADIOISOTOPE	0.397025	6,556	56.00
57.00	05700	CT SCAN	0.067702	10,802	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.132695	12,186	58.00
60.00	06000	LABORATORY	0.242026	91,795	60.00
64.00	06400	INTRAVENOUS THERAPY	1.362054	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.986102	67,763	65.00
66.00	06600	PHYSICAL THERAPY	0.362688	99,798	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.519275	25,788	67.00
68.00	06800	SPEECH PATHOLOGY	0.418410	900	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045374	1,731	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.343432	86,692	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.381390	89,971	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.942127	57	75.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
90.00	09000	CLINIC	0.000000	0	90.00
91.00	09100	EMERGENCY	0.515461	20	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.517527	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		520,887	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)		520,887	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141310	Period: From 04/01/2015 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/24/2016 4:59 pm
		Title XVIII	Hospital	Cost
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			3,894,340 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			0 2.00
3.00	PPS payments			0 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
6.00	Line 2 times line 5			0 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			3,894,340 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			3,933,283 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)			10,481 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			1,747,457 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			2,175,345 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0 28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			2,175,345 30.00
31.00	Primary payer payments			2,655 31.00
32.00	Subtotal (line 30 minus line 31)			2,172,690 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)			353,130 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			229,535 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			315,009 36.00
37.00	Subtotal (see instructions)			2,402,225 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)			2,402,225 40.00
40.01	Sequestration adjustment (see instructions)			48,045 40.01
41.00	Interim payments			2,288,052 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			66,128 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 04/01/2015
To 09/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
2/24/2016 4:59 pm

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		1,677,578		2,288,052	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,677,578		2,288,052	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		66,128	6.01	
6.02	SETTLEMENT TO PROGRAM		27,262		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,650,316		2,354,180	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

Period: From 04/01/2015

Worksheet E-1

Component CCN: 14Z310

To 09/30/2015

Part I
Date/Time Prepared:
2/24/2016 4:59 pm

Title XVIII

Swing Beds - SNF

Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		924,447		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		924,447		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		35,679		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		960,126		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	Period: From 04/01/2015 To 09/30/2015	Worksheet E-2
		Component CCN: 14Z310		Date/Time Prepared: 2/24/2016 4:59 pm
		Title XVIII	Swing Beds - SNF	Cost
			Part A	Part B
			1.00	2.00
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		763,983	0 1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			0 2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)		218,257	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		425	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	0 7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		982,240	0 8.00
9.00	Primary payer payments (see instructions)		0	0 9.00
10.00	Subtotal (line 8 minus line 9)		982,240	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)		982,240	0 12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)		2,520	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)		979,720	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	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)		979,720	0 19.00
19.01	Sequestration adjustment (see instructions)		19,594	0 19.01
20.00	Interim payments		924,447	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)		35,679	0 22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0 23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141310	Period: From 04/01/2015 To 09/30/2015	Worksheet E-3 Part V Date/Time Prepared: 2/24/2016 4:59 pm
		Title VIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			1,813,703 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			1,813,703 4.00
5.00	Primary payer payments			370 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1,825,303 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			1,825,303 19.00
20.00	Deductibles (exclude professional component)			163,551 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,661,752 22.00
23.00	Coinsurance			0 23.00
24.00	Subtotal (line 22 minus line 23)			1,661,752 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			34,222 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			22,244 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			20,682 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,683,996 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)			1,683,996 30.00
30.01	Sequestration adjustment (see instructions)			33,680 30.01
31.00	Interim payments			1,677,578 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)			-27,262 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			100,582 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 04/01/2015
To 09/30/2015

Worksheet G

Date/Time Prepared:
2/24/2016 4:59 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	1,380,337	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	7,330,350	0	0	0	4.00
5.00	Other receivable	408,952	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-3,246,741	0	0	0	6.00
7.00	Inventory	556,029	0	0	0	7.00
8.00	Prepaid expenses	346,437	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)	6,775,364	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,927,000	0	0	0	12.00
13.00	Land improvements	2,096,452	0	0	0	13.00
14.00	Accumulated depreciation	-1,294,801	0	0	0	14.00
15.00	Buildings	16,169,730	0	0	0	15.00
16.00	Accumulated depreciation	-5,282,763	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	3,591,095	0	0	0	19.00
20.00	Accumulated depreciation	-2,698,367	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	11,344,468	0	0	0	23.00
24.00	Accumulated depreciation	-9,346,847	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)	16,505,967	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	4,634,196	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)	4,634,196	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	27,915,527	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	2,320,206	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,245,152	0	0	0	38.00
39.00	Payroll taxes payable	141,187	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,920,477	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	829,248	0	0	0	43.00
44.00	Other current liabilities	439,049	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,895,319	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	30,615,607	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	24,369	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	30,639,976	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	37,535,295	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	-9,619,768				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)	-9,619,768	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	27,915,527	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet G-1

Date/Time Prepared:
2/24/2016 4:59 pm

		General Fund		Special Purpose Fund		Endowment Fund
		1.00	2.00	3.00	4.00	5.00
1.00	Fund balances at beginning of period		8,647,287		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-399,081			2.00
3.00	Total (sum of line 1 and line 2)		8,248,206		0	3.00
4.00	PERMANENT RESTRICTED FUNDS	620,509		0		4.00
5.00	TEMPORARY RESTRICTED FUNDS	976,674		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		1,597,183		0	10.00
11.00	Subtotal (line 3 plus line 10)		9,845,389		0	11.00
12.00	RESTRICTED CAPITAL	41,868		0		12.00
13.00	RESTRICTED ENDOWMENT	619,135		0		13.00
14.00	UNRESTRICTED CAPITAL	2,619,841		0		14.00
15.00	OPERATIONS	16,184,313		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		19,465,157		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		-9,619,768		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	PERMANENT RESTRICTED FUNDS		0			4.00
5.00	TEMPORARY RESTRICTED FUNDS		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	RESTRICTED CAPITAL		0			12.00
13.00	RESTRICTED ENDOWMENT		0			13.00
14.00	UNRESTRICTED CAPITAL		0			14.00
15.00	OPERATIONS		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 04/01/2015
To 09/30/2015

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/24/2016 4:59 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	1,496,170		1,496,170	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	433,967		433,967	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,930,137		1,930,137	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	214,313		214,313	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)	214,313		214,313	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,144,450		2,144,450	17.00
18.00	Ancillary services	3,294,376		3,294,376	18.00
19.00	Outpatient services	0	25,242,643	25,242,643	19.00
20.00	RURAL HEALTH CLINIC	0	1,044,243	1,044,243	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		0	0	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	138,611	2,130,866	2,269,477	27.00
27.01	PHYSICIAN PRIVATE OFFICE	0	2,262,452	2,262,452	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,577,437	30,680,204	36,257,641	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		16,490,313		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)		16,490,313		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet G-3

Date/Time Prepared:
2/24/2016 4:59 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	36,257,641	1.00
2.00	Less contractual allowances and discounts on patients' accounts	19,766,362	2.00
3.00	Net patient revenues (line 1 minus line 2)	16,491,279	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	16,490,313	4.00
5.00	Net income from service to patients (line 3 minus line 4)	966	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	37,391	6.00
7.00	Income from investments	3,103	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	513	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	35,612	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	4,010	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	835	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	19,103	23.00
24.00	OTHER MISCELLANEOUS	177,292	24.00
24.01	DIETICIAN REVENUE	5,719	24.01
24.02	CHAP PAYMENT	0	24.02
24.03	RENTAL REVENUE	6,575	24.03
24.04	AMB SUPPLIES	7,725	24.04
24.05	OTPT CLINIC	38,579	24.05
24.06	LAB QUAL CN	8,358	24.06
24.07	COMMUNITY HEALTH	4,785	24.07
24.08	CTC REVENUE	5,845	24.08
24.09	MEALS ON WHEELS	11,453	24.09
24.10	ILLINOIS HEALTH CENTER	17,288	24.10
24.11	DR. SCHULER	0	24.11
24.12	LOSS ON DISPOSAL	41,709	24.12
25.00	Total other income (sum of lines 6-24)	425,895	25.00
26.00	Total (line 5 plus line 25)	426,861	26.00
27.00	OTHER EXPENSE	825,942	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	825,942	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-399,081	29.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141310 Component CCN: 148535	Period: From 04/01/2015 To 09/30/2015	Worksheet M-1 Date/Time Prepared: 2/24/2016 4:59 pm
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	178,174	0	178,174	0	178,174	1.00
2.00	Physician Assistant	44,487	0	44,487	0	44,487	2.00
3.00	Nurse Practitioner	72,546	0	72,546	0	72,546	3.00
4.00	Visiting Nurse	146,648	0	146,648	0	146,648	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	9,062	0	9,062	0	9,062	9.00
10.00	Subtotal (sum of lines 1 through 9)	450,917	0	450,917	0	450,917	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	397,567	2,467	400,034	0	400,034	13.00
14.00	Subtotal (sum of lines 11 through 13)	397,567	2,467	400,034	0	400,034	14.00
15.00	Medical Supplies	0	18,961	18,961	0	18,961	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	2,777	2,777	0	2,777	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	21,738	21,738	0	21,738	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	848,484	24,205	872,689	0	872,689	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
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	-1,000	-1,000	0	-1,000	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	-1,000	-1,000	0	-1,000	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	818	818	0	818	29.00
30.00	Administrative Costs	0	10,746	10,746	-2,103	8,643	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	11,564	11,564	-2,103	9,461	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	848,484	34,769	883,253	-2,103	881,150	32.00

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

Provider CCN: 141310

Period:
From 04/01/2015
To 09/30/2015

Worksheet M-1

Component CCN: 148535

Date/Time Prepared:
2/24/2016 4:59 pm

Rural Health
Clinic (RHC) I

Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	178,174	1.00
2.00	Physician Assistant	0	44,487	2.00
3.00	Nurse Practitioner	0	72,546	3.00
4.00	Visiting Nurse	0	146,648	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	9,062	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	450,917	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	400,034	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	400,034	14.00
15.00	Medical Supplies	0	18,961	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	2,777	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	21,738	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	872,689	22.00
COSTS OTHER THAN RHC/FQHC SERVICES				
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	-1,000	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	-1,000	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	818	29.00
30.00	Administrative Costs	0	8,643	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	9,461	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	881,150	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141310	Period: From 04/01/2015 To 09/30/2015	Worksheet M-2
		Component CCN: 148535		Date/Time Prepared: 2/24/2016 4:59 pm
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	0.88	2,666	4,200	3,696	1.00
2.00	Physician Assistant	1.25	1,531	2,100	2,625	2.00
3.00	Nurse Practitioner	1.92	1,735	2,100	4,032	3.00
4.00	Subtotal (sum of lines 1 through 3)	4.05	5,932		10,353	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)	4.05	5,932		10,353	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)				872,689	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)				-1,000	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)				871,689	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)				1.001147	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)				9,461	14.00
15.00	Parent provider overhead allocated to facility (see instructions)				862,523	15.00
16.00	Total overhead (sum of lines 14 and 15)				871,984	16.00
17.00	Allowable GME overhead (see instructions)				0	17.00
18.00	Subtotal (see instructions)				871,984	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)				872,984	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)				1,745,673	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141310	Period: From 04/01/2015 To 09/30/2015	Worksheet M-3
		Component CCN: 148535		Date/Time Prepared: 2/24/2016 4:59 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,745,673	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		16,365	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,729,308	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		10,353	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)		10,353	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		167.03	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	167.03	167.03	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,264	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	378,156	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) *		378,156	16.00
16.01	Total program charges (see instructions)(from contractor's records)		320,007	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.)		299,334	16.04
16.05	Total program cost (see instructions)		299,334	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		3,989	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		60,839	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		299,334	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		11,192	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		310,526	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)		310,526	26.00
26.01	Sequestration adjustment (see instructions)		6,211	26.01
27.00	Interim payments		121,388	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)		182,927	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141310 Component CCN: 148535	Period: From 04/01/2015 To 09/30/2015	Worksheet M-4 Date/Time Prepared: 2/24/2016 4:59 pm
		Title XVIII	Rural Health Clinic (RHC) I	Cost
		Pneumococcal 1.00	Influenza 2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	450,917	450,917	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001187	0.001187	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	535	535	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	6,990	126	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	7,525	661	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	872,689	872,689	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	871,984	871,984	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.008623	0.000757	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	7,519	660	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	15,044	1,321	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	48	14	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	313.42	94.36	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	33	9	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	10,343	849	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		16,365	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		11,192	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141310 Component CCN: 148535	Period: From 04/01/2015 To 09/30/2015	Worksheet M-5 Date/Time Prepared: 2/24/2016 4:59 pm
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		121,388	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		121,388	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		182,927	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		304,315	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00