

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: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/18/2015 4:12 pm
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 11/18/2015 Time: 4:12 pm	
	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.		
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 FAIRFIELD MEMORIAL HOSPITAL (141311) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 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	17,626	-88,929	-45,276	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	0	4	0	0	7.00
8.00 NURSING FACILITY	0	0	0	0	0	8.00
9.00 HOME HEALTH AGENCY I	0	0	151	0	0	9.00
10.00 RURAL HEALTH CLINIC I	0	0	56,404	0	0	10.00
200.00 Total	0	17,626	-32,370	-45,276	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: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/18/2015 4:11 pm
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	1.00	2.00	3.00	4.00							
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 303 NW 11TH STREET		PO Box:							1.00	
2.00	City: FAIRFIELD		State: IL		Zip Code: 62837		County: WAYNE				2.00
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
							V	XVIII	XIX		
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00			
Hospital and Hospital-Based Component Identification:											
3.00	Hospital	FAIRFIELD MEMORIAL HOSPITAL	141311	14999	1	04/01/2001	N	O	O	3.00	
4.00	Subprovider - IPF									4.00	
5.00	Subprovider - IRF									5.00	
6.00	Subprovider - (Other)									6.00	
7.00	Swing Beds - SNF									7.00	
8.00	Swing Beds - NF									8.00	
9.00	Hospital-Based SNF	FAIRFIELD MEMORIAL HOSPITAL	145552	14999		03/26/1985	N	P	N	9.00	
10.00	Hospital-Based NF									10.00	
11.00	Hospital-Based OLTC									11.00	
12.00	Hospital-Based HHA	FAIRFIELD MEMORIAL HOSPITAL HHA	147612	14999		05/01/1995	N	P	N	12.00	
13.00	Separately Certified ASC									13.00	
14.00	Hospital-Based Hospice									14.00	
15.00	Hospital-Based Health Clinic - RHC	FAIRFIELD RHC	148500	14999		03/13/2009	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)					07/01/2014		06/30/2015		20.00	
21.00	Type of Control (see instructions)							2		21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.					N		N		22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N		N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N		N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N		N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							2		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		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		25.00	

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		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		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		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		47.00	
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N		N		48.00	
Teaching Hospitals							
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N				59.00	
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	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 Site	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	Unweighted FTEs Nonprovi der Site	Unweighted 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 1.00	XIX 2.00			
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	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	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	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)	N			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 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
					1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.				N	110.00
					1.00	
					2.00	
					3.00	
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, 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.	0			118.00	
		Premiums 1.00	Losses 2.00	Insurance 3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	118.01	
					1.00	
					2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE				119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/18/2015 4:11 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)			140.00
	1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name:	Contractor's Name:	Contractor's Number:	
142.00	Street:	PO Box:		
143.00	City:	State:	Zip Code:	
				1.00
144.00	Are provider based physicians' costs included in Worksheet A?			144.00

		Part A	Part B	Title V	Title XIX		
		1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	157.00	
158.00	SUBPROVIDER					158.00	
159.00	SNF	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00	
161.00	CMHC		N	N	N	161.00	
					1.00		
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	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
					1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.				Y	167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)				915,314	168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)				0.00	169.00	
		Beginning		Ending			
		1.00		2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			07/01/2014	06/30/2015	170.00	
					1.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)				N	171.00	

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/18/2015 4:11 pm	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	C	10/31/2014	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		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	10/13/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/18/2015 4:11 pm
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	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			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			N	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RI CH		FERRI ELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLI ANT MANAGEMENT SERVICES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923832		RFERRI ELL@ALLI ANTMANAGEMENT.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)	10/13/2015	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REIMBURSEMENT MANAGER	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: 141311

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

Worksheet S-3
Part I
Date/Time Prepared:
11/18/2015 4:11 pm

Component	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	52,608.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		21	7,665	52,608.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	4	1,460	12,408.00	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	43.00				0	13.00
14.00 Total (see instructions)		25	9,125	65,016.00	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	44.00	30	10,950		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	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)		55				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: 141311

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

Worksheet S-3
Part I
Date/Time Prepared:
11/18/2015 4:11 pm

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	1,719	192	2,192			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	1,719	192	2,192			7.00
8.00 INTENSIVE CARE UNIT	158	21	517			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		0	0			13.00
14.00 Total (see instructions)	1,877	213	2,709	0.00	168.58	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	898	0	6,991	0.00	19.17	19.00
20.00 NURSING FACILITY		0	0	0.00	0.00	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	2,642	0	3,526	0.00	4.88	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	6,102	0	18,259	0.00	26.87	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	219.50	27.00
28.00 Observation Bed Days		0	807			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: 141311

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

Worksheet S-3
Part I
Date/Time Prepared:
11/18/2015 4:11 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	567	74	799	1.00
2.00 HMO and other (see instructions)			3	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	567	74	799	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	0.00					19.00
20.00 NURSING FACILITY	0.00					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 WAGE RELATED COSTS		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet S-3 Part IV Date/Time Prepared: 11/18/2015 4:11 pm
			Amount Reported	
			1.00	
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		128,387	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		1,417,148	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		51,007	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		105,112	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		749,227	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		21,342	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		2,472,223	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 141311 Component CCN: 147612		Period: From 07/01/2014 To 06/30/2015		Worksheet S-4 Date/Time Prepared: 11/18/2015 4:11 pm	
				Home Health Agency I		PPS	
				1.00			
0.00	County			WAYNE		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	0	0	0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	123.00	0.00	54.00	177.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			0.00	0.00	0.00	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	0.00	0.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	14999					20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	1,277	460	66	1	1,804	21.00
22.00	Skilled Nursing Visit Charges	133,430	49,610	6,710	110	189,860	22.00
23.00	Physical Therapy Visits	633	9	12	7	661	23.00
24.00	Physical Therapy Visit Charges	67,760	990	1,210	770	70,730	24.00
25.00	Occupational Therapy Visits	145	8	3	4	160	25.00
26.00	Occupational Therapy Visit Charges	15,950	880	220	440	17,490	26.00
27.00	Speech Pathology Visits	9	0	0	0	9	27.00
28.00	Speech Pathology Visit Charges	1,035	0	0	0	1,035	28.00
29.00	Medical Social Service Visits	0	0	0	0	0	29.00
30.00	Medical Social Service Visit Charges	0	0	0	0	0	30.00
31.00	Home Health Aide Visits	8	0	0	0	8	31.00
32.00	Home Health Aide Visit Charges	496	0	0	0	496	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	2,072	477	81	12	2,642	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	218,671	51,480	8,140	1,320	279,611	35.00
36.00	Total Number of Episodes (standard/non outlier)	139		24	1	164	36.00
37.00	Total Number of Outlier Episodes		10		0	10	37.00
38.00	Total Non-Routine Medical Supply Charges	48,570	5,406	2,428	0	56,404	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141311

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

Worksheet S-7

Date/Time Prepared:
11/18/2015 4:11 pm

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N			2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	0 3.00
4.00		RUL	0	0	0 4.00
5.00		RVX	0	0	0 5.00
6.00		RVL	0	0	0 6.00
7.00		RHX	0	0	0 7.00
8.00		RHL	18	0	18 8.00
9.00		RMX	0	0	0 9.00
10.00		RML	0	0	0 10.00
11.00		RLX	0	0	0 11.00
12.00		RUC	15	0	15 12.00
13.00		RUB	0	0	0 13.00
14.00		RUA	0	0	0 14.00
15.00		RVC	83	0	83 15.00
16.00		RVB	81	0	81 16.00
17.00		RVA	201	0	201 17.00
18.00		RHC	58	0	58 18.00
19.00		RHB	90	0	90 19.00
20.00		RHA	130	0	130 20.00
21.00		RMC	5	0	5 21.00
22.00		RMB	20	0	20 22.00
23.00		RMA	66	0	66 23.00
24.00		RLB	0	0	0 24.00
25.00		RLA	0	0	0 25.00
26.00		ES3	0	0	0 26.00
27.00		ES2	0	0	0 27.00
28.00		ES1	0	0	0 28.00
29.00		HE2	14	0	14 29.00
30.00		HE1	0	0	0 30.00
31.00		HD2	0	0	0 31.00
32.00		HD1	0	0	0 32.00
33.00		HC2	47	0	47 33.00
34.00		HC1	12	0	12 34.00
35.00		HB2	0	0	0 35.00
36.00		HB1	6	0	6 36.00
37.00		LE2	0	0	0 37.00
38.00		LE1	0	0	0 38.00
39.00		LD2	0	0	0 39.00
40.00		LD1	0	0	0 40.00
41.00		LC2	0	0	0 41.00
42.00		LC1	0	0	0 42.00
43.00		LB2	0	0	0 43.00
44.00		LB1	0	0	0 44.00
45.00		CE2	0	0	0 45.00
46.00		CE1	1	0	1 46.00
47.00		CD2	0	0	0 47.00
48.00		CD1	3	0	3 48.00
49.00		CC2	0	0	0 49.00
50.00		CC1	6	0	6 50.00
51.00		CB2	26	0	26 51.00
52.00		CB1	15	0	15 52.00
53.00		CA2	1	0	1 53.00
54.00		CA1	0	0	0 54.00
55.00		SE3	0	0	0 55.00
56.00		SE2	0	0	0 56.00
57.00		SE1	0	0	0 57.00
58.00		SSC	0	0	0 58.00
59.00		SSB	0	0	0 59.00
60.00		SSA	0	0	0 60.00
61.00		IB2	0	0	0 61.00
62.00		IB1	0	0	0 62.00
63.00		IA2	0	0	0 63.00
64.00		IA1	0	0	0 64.00
65.00		BB2	0	0	0 65.00
66.00		BB1	0	0	0 66.00
67.00		BA2	0	0	0 67.00
68.00		BA1	0	0	0 68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 141311

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

Worksheet S-7

Date/Time Prepared:
11/18/2015 4:11 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		898	0	898	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	

201.00 SNF SERVICES
 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).
 14999 14999 201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,004,498			207.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2014 To 06/30/2015	Worksheet S-8 Date/Time Prepared: 11/18/2015 4:11 pm Cost
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		1.00		
1.00	Clinic Address and Identification Street	303 NW 11TH STREET		1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	FAIRFIELD	IL	62837
		1.00		
3.00	FOHCs ONLY: Designation - Enter "R" for rural or "U" for urban			0
		Grant Award	Date	
		1.00	2.00	
Source of Federal Funds				
4.00	Community Health Center (Section 330(d), PHS Act)	0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0		6.00
7.00	Appalachian Regional Commission	0		7.00
8.00	Look-Alikes	0		8.00
9.00	OTHER (SPECIFY)	0		9.00
		1.00		
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
		Sunday		Monday
		from	to	from
		1.00	2.00	3.00
		Tuesday		from
				5.00
11.00	Facility hours of operations (1) Clinic	09:00	05:00	09:00
		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
		Provider name		CCN number
		1.00		2.00
14.00	Provider name, CCN number	Y/N	V	XVIII
		1.00	2.00	3.00
				XIX
				Total Visits
				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)			
		County		
		4.00		
2.00	City, State, ZIP Code, County	WAYNE		2.00
		Tuesday		Wednesday
		to	from	to
		6.00	7.00	8.00
		Thursday		from
				to
				10.00
11.00	Facility hours of operations (1) Clinic	05:00	09:00	05:00
		09:00	05:00	09:00
		05:00	09:00	05:00
				11.00

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

Provider CCN: 141311
Component CCN: 148500

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

Worksheet S-8
Date/Time Prepared:
11/18/2015 4:11 pm
Cost

	Friday		Saturday			
	from	to	from	to		
	11.00	12.00	13.00	14.00		
11.00 Facility hours of operations (1) Clinic	09:00	05:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet S-10 Date/Time Prepared: 11/18/2015 4:11 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)		0.352411	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		492,964	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		2,967,843	5.00	
6.00	Medicaid charges		13,801,656	6.00	
7.00	Medicaid cost (line 1 times line 6)		4,863,855	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)		1,403,048	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)		1,403,048	19.00	
			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	96,100	12,111	108,211	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	33,867	4,268	38,135	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	33,867	4,268	38,135	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)		2,453,588	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		805,244	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		1,648,344	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		580,895	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		619,030	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		2,022,078	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141311

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

Worksheet A
Date/Time Prepared:
11/18/2015 4:11 pm

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
	1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS							
1.00 00100	CAP REL COSTS-BLDG & FIXT		1,466,963	1,466,963	244,698	1,711,661	1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		0	0	513,208	513,208	2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	99,869	2,478,872	2,578,741	0	2,578,741	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	1,104,724	2,695,385	3,800,109	-11,142	3,788,967	5.00
6.00 00600	MAINTENANCE & REPAIRS	310,084	321,984	632,068	-14,850	617,218	6.00
7.00 00700	OPERATION OF PLANT	0	559,178	559,178	0	559,178	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	396,596	396,596	0	396,596	8.00
9.00 00900	HOUSEKEEPING	301,346	148,838	450,184	0	450,184	9.00
10.00 01000	DIETARY	138,591	646,099	784,690	-319,538	465,152	10.00
11.00 01100	CAFETERIA	0	0	0	277,081	277,081	11.00
13.00 01300	NURSING ADMINISTRATION	225,149	14,346	239,495	0	239,495	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	243,543	117,210	360,753	0	360,753	16.00
17.00 01700	SOCIAL SERVICE	90,095	7,944	98,039	0	98,039	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000	ADULTS & PEDIATRICS	1,347,982	117,036	1,465,018	0	1,465,018	30.00
31.00 03100	INTENSIVE CARE UNIT	221,537	4,769	226,306	0	226,306	31.00
43.00 04300	NURSERY	0	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	647,414	72,428	719,842	-3,003	716,839	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000	OPERATING ROOM	1,016,481	322,514	1,338,995	-93,758	1,245,237	50.00
52.00 05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0	52.00
54.00 05400	RADIOLOGY - DIAGNOSTIC	424,215	1,069,051	1,493,266	-223,467	1,269,799	54.00
60.00 06000	LABORATORY	752,256	1,190,766	1,943,022	-109,410	1,833,612	60.00
65.00 06500	RESPIRATORY THERAPY	159,041	150,876	309,917	-97,998	211,919	65.00
66.00 06600	PHYSICAL THERAPY	677,235	20,293	697,528	0	697,528	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	82,877	82,877	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	47,990	740,363	788,353	-60,656	727,697	71.00
72.00 07200	IMP. DEV CHARGED TO PATIENT	0	0	0	60,656	60,656	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	224,269	1,188,965	1,413,234	0	1,413,234	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800	RURAL HEALTH CLINIC	1,983,951	267,882	2,251,833	0	2,251,833	88.00
90.00 09000	CLINIC	215,643	122,078	337,721	0	337,721	90.00
90.01 09001	WOUND CARE	26,001	207,121	233,122	0	233,122	90.01
90.02 09002	CLINIC	15,485	7,026	22,511	0	22,511	90.02
91.00 09100	EMERGENCY	582,773	1,808,124	2,390,897	0	2,390,897	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00 10100	HOME HEALTH AGENCY	256,190	69,124	325,314	0	325,314	101.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300	INTEREST EXPENSE		354,159	354,159	-244,698	109,461	113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	11,111,864	16,565,990	27,677,854	0	27,677,854	118.00
NONREIMBURSABLE COST CENTERS							
194.00 07950	DR. OFFICE	0	0	0	0	0	194.00
200.00	TOTAL (SUM OF LINES 118-199)	11,111,864	16,565,990	27,677,854	0	27,677,854	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141311

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

Worksheet A
Date/Time Prepared:
11/18/2015 4:11 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	-500,358	1,211,303	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	513,208	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,578,741	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,060,025	2,728,942	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	617,218	6.00
7.00	00700	OPERATION OF PLANT	0	559,178	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	396,596	8.00
9.00	00900	HOUSEKEEPING	0	450,184	9.00
10.00	01000	DIETARY	0	465,152	10.00
11.00	01100	CAFETERIA	-41,591	235,490	11.00
13.00	01300	NURSING ADMINISTRATION	0	239,495	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-7,262	353,491	16.00
17.00	01700	SOCIAL SERVICE	0	98,039	17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-240,802	1,224,216	30.00
31.00	03100	INTENSIVE CARE UNIT	0	226,306	31.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	716,839	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-487,638	757,599	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,615	1,271,414	54.00
60.00	06000	LABORATORY	0	1,833,612	60.00
65.00	06500	RESPIRATORY THERAPY	0	211,919	65.00
66.00	06600	PHYSICAL THERAPY	0	697,528	66.00
69.00	06900	ELECTROCARDIOLOGY	-44,493	38,384	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	727,697	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	60,656	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,413,234	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	2,251,833	88.00
90.00	09000	CLINIC	0	337,721	90.00
90.01	09001	WOUND CARE	0	233,122	90.01
90.02	09002	CLINIC	0	22,511	90.02
91.00	09100	EMERGENCY	-1,203,480	1,187,417	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	HOME HEALTH AGENCY	0	325,314	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	-109,461	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-3,693,495	23,984,359	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	DR. OFFICE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	-3,693,495	23,984,359	200.00

Provider CCN: 141311

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

Worksheet A-6
Date/Time Prepared:
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		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
A - CAFETERIA						
1.00	CAFETERIA	11.00	48,938	228,143	1.00	
	TOTALS		48,938	228,143		
C - EKG						
1.00	ELECTROCARDIOLOGY	69.00	38,384	44,493	1.00	
	TOTALS		38,384	44,493		
D - RENTAL						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	513,208	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	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
	TOTALS		0	513,208		
E - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	244,698	1.00	
	TOTALS		0	244,698		
F - IMPLANTABLE DEVICE						
1.00	IMP. DEV CHARGED TO PATIENT	72.00	0	60,656	1.00	
	TOTALS		0	60,656		
500.00	Grand Total: Increases		87,322	1,091,198	500.00	

Provider CCN: 141311

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

Worksheet A-6
Date/Time Prepared:
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA							
1.00	DIETARY	10.00	48,938	228,143	0		1.00
	TOTALS		48,938	228,143			
C - EKG							
1.00	RESPIRATORY THERAPY	65.00	38,384	44,493	0		1.00
	TOTALS		38,384	44,493			
D - RENTAL							
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	11,142	0		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	14,850	0		3.00
4.00	DIETARY	10.00	0	42,457	0		4.00
12.00	SKILLED NURSING FACILITY	44.00	0	3,003	0		12.00
13.00	OPERATING ROOM	50.00	0	93,758	0		13.00
14.00	RADIOLOGY - DIAGNOSTIC	54.00	0	223,467	0		14.00
15.00	LABORATORY	60.00	0	109,410	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	15,121	0		16.00
	TOTALS		0	513,208			
E - INTEREST							
1.00	INTEREST EXPENSE	113.00	0	244,698	9		1.00
	TOTALS		0	244,698			
F - IMPLANTABLE DEVICE							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	60,656	0		1.00
	TOTALS		0	60,656			
500.00	Grand Total: Decreases		87,322	1,091,198			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141311

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

Worksheet A-7
Part I
Date/Time Prepared:
11/18/2015 4:11 pm

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	421,396	13,090	0	13,090	0 1.00
2.00	Land Improvements	640,428	0	0	0	0 2.00
3.00	Buildings and Fixtures	23,150,257	873,488	0	873,488	0 3.00
4.00	Building Improvements	0	0	0	0	0 4.00
5.00	Fixed Equipment	1,236,239	262,671	0	262,671	0 5.00
6.00	Movable Equipment	10,464,526	323,322	0	323,322	0 6.00
7.00	HIT designated Assets	0	0	0	0	0 7.00
8.00	Subtotal (sum of lines 1-7)	35,912,846	1,472,571	0	1,472,571	0 8.00
9.00	Reconciling Items	0	0	0	0	0 9.00
10.00	Total (line 8 minus line 9)	35,912,846	1,472,571	0	1,472,571	0 10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	434,486	0			1.00
2.00	Land Improvements	640,428	0			2.00
3.00	Buildings and Fixtures	24,023,745	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	1,498,910	0			5.00
6.00	Movable Equipment	10,787,848	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	37,385,417	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	37,385,417	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141311

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

Worksheet A-7
Part II
Date/Time Prepared:
11/18/2015 4:11 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	1,466,963	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,466,963	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	1,466,963				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	1,466,963				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141311

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

Worksheet A-7
Part III
Date/Time Prepared:
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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	1,466,963	0	1,466,963	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1,466,963	0	1,466,963	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	1,211,303	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	513,208	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,724,511	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,211,303	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	513,208	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,724,511	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 141311

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

Worksheet A-8

Date/Time Prepared:
11/18/2015 4:11 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 #			
			3.00	4.00			
		1.00	2.00	3.00	4.00	5.00	
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)	B	-109,461		INTEREST EXPENSE	113.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-5,810		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)		0			0.00	0	8.00
9.00 Parking lot (chapter 21)		0			0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-1,976,413				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	1,615				0	12.00
13.00 Laundry and linen service		0			0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-41,591		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	-7,262		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	0	19.00
20.00 Vending machines		0			0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3			RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)				*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** 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			*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)				ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			*** Cost Center Deleted ***	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-236,275		CAP REL COSTS-BLDG & FIXT	1.00	9	32.00
33.00 OFFICE SPACE RENTAL	B	-100,516		CAP REL COSTS-BLDG & FIXT	1.00	9	33.00
33.01 RINARD & WEBER CLINIC	A	-13,567		CAP REL COSTS-BLDG & FIXT	1.00	9	33.01

ADJUSTMENTS TO EXPENSES

Provider CCN: 141311

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

Worksheet A-8

Date/Time Prepared:
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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		
33.02 RECRUITING	A	-130,917	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 ADVERTISING	A	-103,593	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 OTHER REVENUE	B	-233,211	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05 WAYFAIR RENTAL	B	-150,000	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
33.06 PROVIDER TAX	A	-586,494	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07		0		0.00	0	33.07
33.08		0		0.00	0	33.08
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,693,495				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: 141311

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

Worksheet A-8-1

Date/Time Prepared:
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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	54.00	RADIOLOGY - DIAGNOSTIC	209,732	208,117	1.00
2.00	0.00	MRI	0	0	2.00
3.00	0.00		0	0	3.00
4.00	0.00		0	0	4.00
5.00	0	0	209,732	208,117	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	G	DSSI	15.00	DSSI	15.00	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:	OTHER				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: 141311

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

Worksheet A-8-1

Date/Time Prepared:
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	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	1,615	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	1,615			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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	MRI		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: 141311

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

Worksheet A-8-2

Date/Time Prepared:
11/18/2015 4:11 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	30.00	ADULTS & PEDIATRICS	240,802	240,802	0	0	0	1.00
2.00	50.00	OPERATING ROOM	487,638	487,638	0	0	0	2.00
3.00	60.00	LABORATORY	17,500	0	17,500	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	44,493	44,493	0	0	0	4.00
5.00	91.00	EMERGENCY	1,623,692	1,203,480	420,212	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			2,414,125	1,976,413	437,712			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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	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	30.00	ADULTS & PEDIATRICS	0	0	0	240,802		1.00
2.00	50.00	OPERATING ROOM	0	0	0	487,638		2.00
3.00	60.00	LABORATORY	0	0	0	0		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	44,493		4.00
5.00	91.00	EMERGENCY	0	0	0	1,203,480		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	1,976,413		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141311

Period:
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	1,211,303	1,211,303			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	513,208		513,208		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,578,741	0	0	2,578,741	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,728,942	235,129	99,619	258,700	3,322,390 5.00
6.00 00600	MAINTENANCE & REPAIRS	617,218	33,477	14,183	72,614	737,492 6.00
7.00 00700	OPERATION OF PLANT	559,178	21,880	9,270	0	590,328 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	396,596	15,119	6,406	0	418,121 8.00
9.00 00900	HOUSEKEEPING	450,184	2,092	886	70,568	523,730 9.00
10.00 01000	DIETARY	465,152	1,549	656	20,995	488,352 10.00
11.00 01100	CAFETERIA	235,490	45,498	19,277	11,460	311,725 11.00
13.00 01300	NURSING ADMINISTRATION	239,495	1,513	641	52,724	294,373 13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	353,491	17,412	7,377	57,032	435,312 16.00
17.00 01700	SOCIAL SERVICE	98,039	1,891	801	21,098	121,829 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,224,216	172,572	73,116	315,665	1,785,569 30.00
31.00 03100	INTENSIVE CARE UNIT	226,306	15,757	6,676	51,879	300,618 31.00
43.00 04300	NURSERY	0	0	0	0	0 43.00
44.00 04400	SKILLED NURSING FACILITY	716,839	101,103	42,836	151,609	1,012,387 44.00
45.00 04500	NURSING FACILITY	0	0	0	0	0 45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	757,599	76,741	32,514	238,035	1,104,889 50.00
52.00 05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0 52.00
54.00 05400	RADIOLOGY - DIAGNOSTIC	1,271,414	54,116	22,928	99,341	1,447,799 54.00
60.00 06000	LABORATORY	1,833,612	26,810	11,359	176,160	2,047,941 60.00
65.00 06500	RESPIRATORY THERAPY	211,919	19,906	8,434	28,255	268,514 65.00
66.00 06600	PHYSICAL THERAPY	697,528	42,661	18,075	158,592	916,856 66.00
69.00 06900	ELECTROCARDIOLOGY	38,384	0	0	8,989	47,373 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	727,697	20,994	8,895	11,238	768,824 71.00
72.00 07200	IMP. DEV CHARGED TO PATIENT	60,656	0	0	0	60,656 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1,413,234	32,247	13,663	52,518	1,511,662 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	2,251,833	175,468	74,343	464,591	2,966,235 88.00
90.00 09000	CLINIC	337,721	20,509	8,689	50,498	417,417 90.00
90.01 09001	WOUND CARE	233,122	25,651	10,868	6,089	275,730 90.01
90.02 09002	CLINIC	22,511	1,064	451	3,626	27,652 90.02
91.00 09100	EMERGENCY	1,187,417	27,448	11,629	136,471	1,362,965 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0 92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	325,314	22,696	9,616	59,994	417,620 101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	23,984,359	1,211,303	513,208	2,578,741	23,984,359 118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	DR. OFFICE	0	0	0	0	0 194.00
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	23,984,359	1,211,303	513,208	2,578,741	23,984,359 202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141311

Period:
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	3,322,390					5.00
6.00	00600	118,587	856,079				6.00
7.00	00700	94,923	19,870	705,121			7.00
8.00	00800	67,233	13,730	11,577	510,661		8.00
9.00	00900	84,214	1,900	1,602	71,360	682,806	9.00
10.00	01000	78,526	1,406	1,186	0	1,170	10.00
11.00	01100	50,124	41,318	34,841	0	34,381	11.00
13.00	01300	47,334	1,374	1,159	0	1,143	13.00
16.00	01600	69,997	15,812	13,333	0	13,157	16.00
17.00	01700	19,590	1,718	1,448	0	1,429	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	287,114	156,715	132,148	109,318	130,403	30.00
31.00	03100	48,338	14,309	12,066	4,949	11,907	31.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	162,789	91,814	77,420	108,731	76,398	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	177,663	69,689	58,765	62,161	57,989	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	232,802	49,143	41,439	34,103	40,892	54.00
60.00	06000	329,303	24,346	20,530	4,866	20,259	60.00
65.00	06500	43,176	18,077	15,243	8,750	15,042	65.00
66.00	06600	147,428	38,741	32,668	30,511	32,237	66.00
69.00	06900	7,617	0	0	10,880	0	69.00
71.00	07100	123,625	19,065	16,076	0	15,864	71.00
72.00	07200	9,753	0	0	0	0	72.00
73.00	07300	243,071	29,284	24,693	0	24,367	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	476,968	159,346	134,366	5,127	132,592	88.00
90.00	09000	67,119	18,625	15,705	0	15,498	90.00
90.01	09001	44,337	23,294	19,643	0	19,383	90.01
90.02	09002	4,446	966	815	0	804	90.02
91.00	09100	219,161	24,926	21,018	59,905	20,741	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	67,152	20,611	17,380	0	17,150	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		3,322,390	856,079	705,121	510,661	682,806	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		3,322,390	856,079	705,121	510,661	682,806	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141311

Period:
From 07/01/2014
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	570,640					10.00
11.00	01100	0	472,389				11.00
13.00	01300	0	8,648	354,031			13.00
16.00	01600	0	20,293	0	567,904		16.00
17.00	01700	0	6,559	0	0	152,573	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	128,962	76,297	127,836	46,198	152,573	30.00
31.00	03100	30,406	11,384	19,073	3,934	0	31.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	411,272	54,387	91,124	8,453	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	33,870	56,748	36,475	0	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	0	25,104	0	137,015	0	54.00
60.00	06000	0	55,262	0	103,361	0	60.00
65.00	06500	0	8,637	0	30,635	0	65.00
66.00	06600	0	27,587	0	26,850	0	66.00
69.00	06900	0	2,748	0	12,270	0	69.00
71.00	07100	0	5,354	0	35,892	0	71.00
72.00	07200	0	0	0	1,184	0	72.00
73.00	07300	0	9,444	0	47,040	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	76,210	0	31,900	0	88.00
90.00	09000	0	13,528	0	10,608	0	90.00
90.01	09001	0	498	0	5,681	0	90.01
90.02	09002	0	1,215	0	0	0	90.02
91.00	09100	0	35,364	59,250	30,408	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		570,640	472,389	354,031	567,904	152,573	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		570,640	472,389	354,031	567,904	152,573	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141311

Period:
From 07/01/2014
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
16.00	01600				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	3,133,133	0	3,133,133	30.00
31.00	03100	456,984	0	456,984	31.00
43.00	04300	0	0	0	43.00
44.00	04400	2,094,775	0	2,094,775	44.00
45.00	04500	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	1,658,249	0	1,658,249	50.00
52.00	05200	0	0	0	52.00
54.00	05400	2,008,297	0	2,008,297	54.00
60.00	06000	2,605,868	0	2,605,868	60.00
65.00	06500	408,074	0	408,074	65.00
66.00	06600	1,252,878	0	1,252,878	66.00
69.00	06900	80,888	0	80,888	69.00
71.00	07100	984,700	0	984,700	71.00
72.00	07200	71,593	0	71,593	72.00
73.00	07300	1,889,561	0	1,889,561	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	3,982,744	0	3,982,744	88.00
90.00	09000	558,500	0	558,500	90.00
90.01	09001	388,566	0	388,566	90.01
90.02	09002	35,898	0	35,898	90.02
91.00	09100	1,833,738	0	1,833,738	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	539,913	0	539,913	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		23,984,359	0	23,984,359	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	0	0	0	194.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		23,984,359	0	23,984,359	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141311

Period:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	235,129	99,619	334,748	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	33,477	14,183	47,660	6.00
7.00 00700	OPERATION OF PLANT	0	21,880	9,270	31,150	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	15,119	6,406	21,525	8.00
9.00 00900	HOUSEKEEPING	0	2,092	886	2,978	9.00
10.00 01000	DIETARY	0	1,549	656	2,205	10.00
11.00 01100	CAFETERIA	0	45,498	19,277	64,775	11.00
13.00 01300	NURSING ADMINISTRATION	0	1,513	641	2,154	13.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	17,412	7,377	24,789	16.00
17.00 01700	SOCIAL SERVICE	0	1,891	801	2,692	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	172,572	73,116	245,688	30.00
31.00 03100	INTENSIVE CARE UNIT	0	15,757	6,676	22,433	31.00
43.00 04300	NURSERY	0	0	0	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	101,103	42,836	143,939	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	76,741	32,514	109,255	50.00
52.00 05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	52.00
54.00 05400	RADIOLOGY - DIAGNOSTIC	0	54,116	22,928	77,044	54.00
60.00 06000	LABORATORY	0	26,810	11,359	38,169	60.00
65.00 06500	RESPIRATORY THERAPY	0	19,906	8,434	28,340	65.00
66.00 06600	PHYSICAL THERAPY	0	42,661	18,075	60,736	66.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,994	8,895	29,889	71.00
72.00 07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	32,247	13,663	45,910	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	175,468	74,343	249,811	88.00
90.00 09000	CLINIC	0	20,509	8,689	29,198	90.00
90.01 09001	WOUND CARE	0	25,651	10,868	36,519	90.01
90.02 09002	CLINIC	0	1,064	451	1,515	90.02
91.00 09100	EMERGENCY	0	27,448	11,629	39,077	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	22,696	9,616	32,312	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	1,211,303	513,208	1,724,511	118.00
NONREIMBURSABLE COST CENTERS						
194.00 07950	DR. OFFICE	0	0	0	0	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	1,211,303	513,208	1,724,511	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141311

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

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	334,748					5.00
6.00	00600	11,948	59,608				6.00
7.00	00700	9,564	1,384	42,098			7.00
8.00	00800	6,774	956	691	29,946		8.00
9.00	00900	8,485	132	96	4,185	15,876	9.00
10.00	01000	7,912	98	71	0	27	10.00
11.00	01100	5,050	2,877	2,080	0	799	11.00
13.00	01300	4,769	96	69	0	27	13.00
16.00	01600	7,052	1,101	796	0	306	16.00
17.00	01700	1,974	120	86	0	33	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	28,928	10,912	7,890	6,411	3,032	30.00
31.00	03100	4,870	996	720	290	277	31.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	16,402	6,393	4,622	6,376	1,776	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	17,900	4,852	3,508	3,645	1,348	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	23,456	3,422	2,474	2,000	951	54.00
60.00	06000	33,179	1,695	1,226	285	471	60.00
65.00	06500	4,350	1,259	910	513	350	65.00
66.00	06600	14,854	2,698	1,950	1,789	750	66.00
69.00	06900	767	0	0	638	0	69.00
71.00	07100	12,456	1,327	960	0	369	71.00
72.00	07200	983	0	0	0	0	72.00
73.00	07300	24,490	2,039	1,474	0	567	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	48,060	11,094	8,022	301	3,082	88.00
90.00	09000	6,763	1,297	938	0	360	90.00
90.01	09001	4,467	1,622	1,173	0	451	90.01
90.02	09002	448	67	49	0	19	90.02
91.00	09100	22,081	1,736	1,255	3,513	482	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	6,766	1,435	1,038	0	399	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		334,748	59,608	42,098	29,946	15,876	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		334,748	59,608	42,098	29,946	15,876	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141311

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

Worksheet B
Part II
Date/Time Prepared:
11/18/2015 4:11 pm

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	10,313					10.00
11.00	01100	0	75,581				11.00
13.00	01300	0	1,384	8,499			13.00
16.00	01600	0	3,247	0	37,291		16.00
17.00	01700	0	1,049	0	0	5,954	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	2,331	12,207	3,069	3,036	5,954	30.00
31.00	03100	550	1,821	458	259	0	31.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	7,432	8,702	2,188	555	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	5,419	1,362	2,397	0	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	0	4,017	0	8,976	0	54.00
60.00	06000	0	8,842	0	6,792	0	60.00
65.00	06500	0	1,382	0	2,013	0	65.00
66.00	06600	0	4,414	0	1,765	0	66.00
69.00	06900	0	440	0	806	0	69.00
71.00	07100	0	857	0	2,359	0	71.00
72.00	07200	0	0	0	78	0	72.00
73.00	07300	0	1,511	0	3,091	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	12,193	0	2,096	0	88.00
90.00	09000	0	2,164	0	697	0	90.00
90.01	09001	0	80	0	373	0	90.01
90.02	09002	0	194	0	0	0	90.02
91.00	09100	0	5,658	1,422	1,998	0	91.00
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	0	0	0	0	0	113.00
118.00		10,313	75,581	8,499	37,291	5,954	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00		0	0	0	0	0	200.00
201.00		0	0	0	0	0	201.00
202.00		10,313	75,581	8,499	37,291	5,954	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141311

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

Worksheet B
Part II
Date/Time Prepared:
11/18/2015 4:11 pm

Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
16.00	01600				16.00
17.00	01700				17.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	329,458	0	329,458	30.00
31.00	03100	32,674	0	32,674	31.00
43.00	04300	0	0	0	43.00
44.00	04400	198,385	0	198,385	44.00
45.00	04500	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	149,686	0	149,686	50.00
52.00	05200	0	0	0	52.00
54.00	05400	122,340	0	122,340	54.00
60.00	06000	90,659	0	90,659	60.00
65.00	06500	39,117	0	39,117	65.00
66.00	06600	88,956	0	88,956	66.00
69.00	06900	2,651	0	2,651	69.00
71.00	07100	48,217	0	48,217	71.00
72.00	07200	1,061	0	1,061	72.00
73.00	07300	79,082	0	79,082	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	334,659	0	334,659	88.00
90.00	09000	41,417	0	41,417	90.00
90.01	09001	44,685	0	44,685	90.01
90.02	09002	2,292	0	2,292	90.02
91.00	09100	77,222	0	77,222	91.00
92.00	09200		0		92.00
OTHER REIMBURSABLE COST CENTERS					
101.00	10100	41,950	0	41,950	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		1,724,511	0	1,724,511	118.00
NONREIMBURSABLE COST CENTERS					
194.00	07950	0	0	0	194.00
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		1,724,511	0	1,724,511	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141311

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

Worksheet B-1
Date/Time Prepared:
11/18/2015 4:11 pm

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	102,472				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		102,472			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	11,011,997		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	19,891	19,891	1,104,724	-3,322,390	20,661,969
6.00 00600	MAINTENANCE & REPAIRS	2,832	2,832	310,084	0	737,492
7.00 00700	OPERATION OF PLANT	1,851	1,851	0	0	590,328
8.00 00800	LAUNDRY & LINEN SERVICE	1,279	1,279	0	0	418,121
9.00 00900	HOUSEKEEPING	177	177	301,346	0	523,730
10.00 01000	DIETARY	131	131	89,654	0	488,352
11.00 01100	CAFETERIA	3,849	3,849	48,938	0	311,725
13.00 01300	NURSING ADMINISTRATION	128	128	225,149	0	294,373
16.00 01600	MEDICAL RECORDS & LIBRARY	1,473	1,473	243,543	0	435,312
17.00 01700	SOCIAL SERVICE	160	160	90,095	0	121,829
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	14,599	14,599	1,347,982	0	1,785,569
31.00 03100	INTENSIVE CARE UNIT	1,333	1,333	221,537	0	300,618
43.00 04300	NURSERY	0	0	0	0	0
44.00 04400	SKILLED NURSING FACILITY	8,553	8,553	647,414	0	1,012,387
45.00 04500	NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	6,492	6,492	1,016,481	0	1,104,889
52.00 05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	0
54.00 05400	RADIOLOGY - DIAGNOSTIC	4,578	4,578	424,215	0	1,447,799
60.00 06000	LABORATORY	2,268	2,268	752,256	0	2,047,941
65.00 06500	RESPIRATORY THERAPY	1,684	1,684	120,658	0	268,514
66.00 06600	PHYSICAL THERAPY	3,609	3,609	677,235	0	916,856
69.00 06900	ELECTROCARDIOLOGY	0	0	38,384	0	47,373
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,776	1,776	47,990	0	768,824
72.00 07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	60,656
73.00 07300	DRUGS CHARGED TO PATIENTS	2,728	2,728	224,269	0	1,511,662
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	14,844	14,844	1,983,951	0	2,966,235
90.00 09000	CLINIC	1,735	1,735	215,643	0	417,417
90.01 09001	WOUND CARE	2,170	2,170	26,001	0	275,730
90.02 09002	CLINIC	90	90	15,485	0	27,652
91.00 09100	EMERGENCY	2,322	2,322	582,773	0	1,362,965
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS						
101.00 10100	HOME HEALTH AGENCY	1,920	1,920	256,190	0	417,620
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	102,472	102,472	11,011,997	-3,322,390	20,661,969
NONREIMBURSABLE COST CENTERS						
194.00 07950	DR. OFFICE	0	0	0	0	0
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	1,211,303	513,208	2,578,741		3,322,390
203.00	Unit cost multiplier (Wkst. B, Part I)	11.820819	5.008275	0.234176		0.160797
204.00	Cost to be allocated (per Wkst. B, Part II)			0		334,748
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.016201

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141311

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

Worksheet B-1

Date/Time Prepared:
11/18/2015 4:11 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	79,749					6.00
7.00	00700	1,851	77,898				7.00
8.00	00800	1,279	1,279	48,905			8.00
9.00	00900	177	177	6,834	76,442		9.00
10.00	01000	131	131	0	131	19,049	10.00
11.00	01100	3,849	3,849	0	3,849	0	11.00
13.00	01300	128	128	0	128	0	13.00
16.00	01600	1,473	1,473	0	1,473	0	16.00
17.00	01700	160	160	0	160	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	14,599	14,599	10,469	14,599	4,305	30.00
31.00	03100	1,333	1,333	474	1,333	1,015	31.00
43.00	04300	0	0	0	0	0	43.00
44.00	04400	8,553	8,553	10,413	8,553	13,729	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	6,492	6,492	5,953	6,492	0	50.00
52.00	05200	0	0	0	0	0	52.00
54.00	05400	4,578	4,578	3,266	4,578	0	54.00
60.00	06000	2,268	2,268	466	2,268	0	60.00
65.00	06500	1,684	1,684	838	1,684	0	65.00
66.00	06600	3,609	3,609	2,922	3,609	0	66.00
69.00	06900	0	0	1,042	0	0	69.00
71.00	07100	1,776	1,776	0	1,776	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	2,728	2,728	0	2,728	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	14,844	14,844	491	14,844	0	88.00
90.00	09000	1,735	1,735	0	1,735	0	90.00
90.01	09001	2,170	2,170	0	2,170	0	90.01
90.02	09002	90	90	0	90	0	90.02
91.00	09100	2,322	2,322	5,737	2,322	0	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	1,920	1,920	0	1,920	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		79,749	77,898	48,905	76,442	19,049	118.00
NONREIMBURSABLE COST CENTERS							
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		856,079	705,121	510,661	682,806	570,640	202.00
203.00		10.734668	9.051850	10.441898	8.932341	29.956428	203.00
204.00		59,608	42,098	29,946	15,876	10,313	204.00
205.00		0.747445	0.540425	0.612330	0.207687	0.541393	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141311

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

Worksheet B-1

Date/Time Prepared:
11/18/2015 4:11 pm

Cost Center Description		CAFETERIA (PAID HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	
		11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100	346,375				11.00
13.00	01300	6,341	154,936			13.00
16.00	01600	14,880	0	67,485,296		16.00
17.00	01700	4,809	0	0	100	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	55,945	55,945	5,489,916	100	30.00
31.00	03100	8,347	8,347	467,519	0	31.00
43.00	04300	0	0	0	0	43.00
44.00	04400	39,879	39,879	1,004,498	0	44.00
45.00	04500	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	24,835	24,835	4,334,542	0	50.00
52.00	05200	0	0	0	0	52.00
54.00	05400	18,407	0	16,280,376	0	54.00
60.00	06000	40,520	0	12,282,918	0	60.00
65.00	06500	6,333	0	3,640,492	0	65.00
66.00	06600	20,228	0	3,190,789	0	66.00
69.00	06900	2,015	0	1,458,092	0	69.00
71.00	07100	3,926	0	4,265,294	0	71.00
72.00	07200	0	0	140,642	0	72.00
73.00	07300	6,925	0	5,590,035	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	55,880	0	3,790,908	0	88.00
90.00	09000	9,919	0	1,260,654	0	90.00
90.01	09001	365	0	675,102	0	90.01
90.02	09002	891	0	0	0	90.02
91.00	09100	25,930	25,930	3,613,519	0	91.00
92.00	09200					92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		346,375	154,936	67,485,296	100	118.00
NONREIMBURSABLE COST CENTERS						
194.00	07950	0	0	0	0	194.00
200.00						200.00
201.00						201.00
202.00		472,389	354,031	567,904	152,573	202.00
203.00		1.363808	2.285014	0.008415	1,525.730000	203.00
204.00		75,581	8,499	37,291	5,954	204.00
205.00		0.218206	0.054855	0.000553	59.540000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141311

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

Worksheet C
Part I
Date/Time Prepared:
11/18/2015 4:11 pm

		Title XVII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		3,133,133	0	3,133,133	30.00
31.00	03100 INTENSIVE CARE UNIT		456,984	0	456,984	31.00
43.00	04300 NURSERY		0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY		2,094,775	0	2,094,775	44.00
45.00	04500 NURSING FACILITY		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		1,658,249	0	1,658,249	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM		0	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC		2,008,297	0	2,008,297	54.00
60.00	06000 LABORATORY		2,605,868	0	2,605,868	60.00
65.00	06500 RESPIRATORY THERAPY	0	408,074	0	408,074	65.00
66.00	06600 PHYSICAL THERAPY	0	1,252,878	0	1,252,878	66.00
69.00	06900 ELECTROCARDIOLOGY		80,888	0	80,888	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		984,700	0	984,700	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT		71,593	0	71,593	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		1,889,561	0	1,889,561	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		3,982,744	0	3,982,744	88.00
90.00	09000 CLINIC		558,500	0	558,500	90.00
90.01	09001 WOUND CARE		388,566	0	388,566	90.01
90.02	09002 CLINIC		35,898	0	35,898	90.02
91.00	09100 EMERGENCY		1,833,738	0	1,833,738	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		843,097	0	843,097	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY		539,913		539,913	101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)		24,827,456	0	24,827,456	200.00
201.00	Less Observation Beds		843,097		843,097	201.00
202.00	Total (see instructions)		23,984,359	0	23,984,359	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141311

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

Worksheet C
Part I
Date/Time Prepared:
11/18/2015 4:11 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XVIII Hospital Cost							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,619,838		4,619,838		30.00
31.00	03100	INTENSIVE CARE UNIT	467,519		467,519		31.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	1,004,498		1,004,498		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	628,375	3,706,167	4,334,542	0.382566	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,145,545	15,134,831	16,280,376	0.123357	54.00
60.00	06000	LABORATORY	1,614,017	10,668,901	12,282,918	0.212154	60.00
65.00	06500	RESPIRATORY THERAPY	686,224	1,802,765	2,488,989	0.163952	65.00
66.00	06600	PHYSICAL THERAPY	1,148,436	2,042,353	3,190,789	0.392655	66.00
69.00	06900	ELECTROCARDIOLOGY	312,947	1,145,145	1,458,092	0.055475	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,027,063	3,389,734	5,416,797	0.181786	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	5,514	135,128	140,642	0.509044	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,504,814	4,085,221	5,590,035	0.338023	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,790,908	3,790,908		88.00
90.00	09000	CLINIC	500	1,260,154	1,260,654	0.443024	90.00
90.01	09001	WOUND CARE	3,000	672,102	675,102	0.575566	90.01
90.02	09002	CLINIC	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	79,846	3,533,673	3,613,519	0.507466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	119,531	750,547	870,078	0.968990	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	572,661	572,661		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	15,367,667	52,690,290	68,057,957		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,367,667	52,690,290	68,057,957		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/18/2015 4:11 pm
		Title XVIII	Hospital	Cost

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0.000000		52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 WOUND CARE	0.000000		90.01
90.02	09002 CLINIC	0.000000		90.02
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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141311

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

Worksheet C
Part I
Date/Time Prepared:
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		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	3,133,133		3,133,133	0	3,133,133	30.00
31.00	03100 INTENSIVE CARE UNIT	456,984		456,984	0	456,984	31.00
43.00	04300 NURSERY	0		0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	2,094,775		2,094,775	0	2,094,775	44.00
45.00	04500 NURSING FACILITY	0		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,658,249		1,658,249	0	1,658,249	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0		0	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	2,008,297		2,008,297	0	2,008,297	54.00
60.00	06000 LABORATORY	2,605,868		2,605,868	0	2,605,868	60.00
65.00	06500 RESPIRATORY THERAPY	408,074	0	408,074	0	408,074	65.00
66.00	06600 PHYSICAL THERAPY	1,252,878	0	1,252,878	0	1,252,878	66.00
69.00	06900 ELECTROCARDIOLOGY	80,888		80,888	0	80,888	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	984,700		984,700	0	984,700	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	71,593		71,593	0	71,593	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,889,561		1,889,561	0	1,889,561	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	3,982,744		3,982,744	0	3,982,744	88.00
90.00	09000 CLINIC	558,500		558,500	0	558,500	90.00
90.01	09001 WOUND CARE	388,566		388,566	0	388,566	90.01
90.02	09002 CLINIC	35,898		35,898	0	35,898	90.02
91.00	09100 EMERGENCY	1,833,738		1,833,738	0	1,833,738	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	843,097		843,097	0	843,097	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100 HOME HEALTH AGENCY	539,913		539,913		539,913	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	24,827,456	0	24,827,456	0	24,827,456	200.00
201.00	Less Observation Beds	843,097		843,097		843,097	201.00
202.00	Total (see instructions)	23,984,359	0	23,984,359	0	23,984,359	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141311

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

Worksheet C
Part I
Date/Time Prepared:
11/18/2015 4:11 pm

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
Title XIX Hospital Cost							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,619,838		4,619,838		30.00
31.00	03100	INTENSIVE CARE UNIT	467,519		467,519		31.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	1,004,498		1,004,498		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	628,375	3,706,167	4,334,542	0.382566	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0.000000	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	1,145,545	15,134,831	16,280,376	0.123357	54.00
60.00	06000	LABORATORY	1,614,017	10,668,901	12,282,918	0.212154	60.00
65.00	06500	RESPIRATORY THERAPY	686,224	1,802,765	2,488,989	0.163952	65.00
66.00	06600	PHYSICAL THERAPY	1,148,436	2,042,353	3,190,789	0.392655	66.00
69.00	06900	ELECTROCARDIOLOGY	312,947	1,145,145	1,458,092	0.055475	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,027,063	3,389,734	5,416,797	0.181786	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	5,514	135,128	140,642	0.509044	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,504,814	4,085,221	5,590,035	0.338023	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	3,790,908	3,790,908	1.050604	88.00
90.00	09000	CLINIC	500	1,260,154	1,260,654	0.443024	90.00
90.01	09001	WOUND CARE	3,000	672,102	675,102	0.575566	90.01
90.02	09002	CLINIC	0	0	0	0.000000	90.02
91.00	09100	EMERGENCY	79,846	3,533,673	3,613,519	0.507466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	119,531	750,547	870,078	0.968990	92.00
OTHER REIMBURSABLE COST CENTERS							
101.00	10100	HOME HEALTH AGENCY	0	572,661	572,661		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	15,367,667	52,690,290	68,057,957		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	15,367,667	52,690,290	68,057,957		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet C Part I Date/Time Prepared: 11/18/2015 4:11 pm
Cost Center Description		PPS Inpatient Ratio 11.00	Title XIX	Hospital Cost
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.000000		50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0.000000		52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.000000		54.00
60.00	06000 LABORATORY	0.000000		60.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 WOUND CARE	0.000000		90.01
90.02	09002 CLINIC	0.000000		90.02
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: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part II Date/Time Prepared: 11/18/2015 4:11 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	149,686	4,334,542	0.034533	288,703	9,970	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0	0	0.000000	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	122,340	16,280,376	0.007515	965,140	7,253	54.00
60.00	06000 LABORATORY	90,659	12,282,918	0.007381	1,303,178	9,619	60.00
65.00	06500 RESPIRATORY THERAPY	39,117	2,488,989	0.015716	502,935	7,904	65.00
66.00	06600 PHYSICAL THERAPY	88,956	3,190,789	0.027879	175,203	4,884	66.00
69.00	06900 ELECTROCARDIOLOGY	2,651	1,458,092	0.001818	174,136	317	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	48,217	5,416,797	0.008901	1,147,554	10,214	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	1,061	140,642	0.007544	5,514	42	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	79,082	5,590,035	0.014147	881,901	12,476	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	334,659	3,790,908	0.088279	0	0	88.00
90.00	09000 CLINIC	41,417	1,260,654	0.032854	0	0	90.00
90.01	09001 WOUND CARE	44,685	675,102	0.066190	2,390	158	90.01
90.02	09002 CLINIC	2,292	0	0.000000	0	0	90.02
91.00	09100 EMERGENCY	77,222	3,613,519	0.021370	66,864	1,429	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	88,654	870,078	0.101892	64,854	6,608	92.00
200.00	Total (lines 50-199)	1,210,698	61,393,441		5,578,372	70,874	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141311

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

Worksheet D
Part IV
Date/Time Prepared:
11/18/2015 4:11 pm

Cost Center Description		Title XVIII				Hospital	
		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	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (Lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141311

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

Worksheet D
Part IV
Date/Time Prepared:
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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			
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,334,542	0.000000	0.000000	288,703	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0.000000	0.000000	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	16,280,376	0.000000	0.000000	965,140	54.00
60.00	06000	LABORATORY	0	12,282,918	0.000000	0.000000	1,303,178	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,488,989	0.000000	0.000000	502,935	65.00
66.00	06600	PHYSICAL THERAPY	0	3,190,789	0.000000	0.000000	175,203	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,458,092	0.000000	0.000000	174,136	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,416,797	0.000000	0.000000	1,147,554	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	140,642	0.000000	0.000000	5,514	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,590,035	0.000000	0.000000	881,901	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	3,790,908	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	1,260,654	0.000000	0.000000	0	90.00
90.01	09001	WOUND CARE	0	675,102	0.000000	0.000000	2,390	90.01
90.02	09002	CLINIC	0	0	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	3,613,519	0.000000	0.000000	66,864	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	870,078	0.000000	0.000000	64,854	92.00
200.00		Total (lines 50-199)	0	61,393,441			5,578,372	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141311

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

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XVIII			Hospital	Cost
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0		50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0	0	0		52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	0	0		54.00
60.00	06000 LABORATORY	0	0	0		60.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 WOUND CARE	0	0	0		90.01
90.02	09002 CLINIC	0	0	0		90.02
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: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/18/2015 4:11 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	0.382566	0	1,279,418	0	0
52.00 05200 LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0	0
54.00 05400 RADIOLOGY - DIAGNOSTIC	0.123357	0	6,677,613	0	0
60.00 06000 LABORATORY	0.212154	0	4,890,524	0	0
65.00 06500 RESPIRATORY THERAPY	0.163952	0	730,122	0	0
66.00 06600 PHYSICAL THERAPY	0.392655	0	687,773	0	0
69.00 06900 ELECTROCARDIOLOGY	0.055475	0	451,423	0	0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181786	0	1,177,093	0	0
72.00 07200 IMP. DEV CHARGED TO PATIENT	0.509044	0	132,098	0	0
73.00 07300 DRUGS CHARGED TO PATIENTS	0.338023	0	2,055,115	2,240	0
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				0
90.00 09000 CLINIC	0.443024	0	1,218,645	0	0
90.01 09001 WOUND CARE	0.575566	0	393,288	0	0
90.02 09002 CLINIC	0.000000	0	0	0	0
91.00 09100 EMERGENCY	0.507466	0	1,169,244	0	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.968990	0	334,393	0	0
200.00 Subtotal (see instructions)		0	21,196,749	2,240	0
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	21,196,749	2,240	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/18/2015 4:11 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	489,462	0	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	823,730	0	54.00
60.00	06000 LABORATORY	1,037,544	0	60.00
65.00	06500 RESPIRATORY THERAPY	119,705	0	65.00
66.00	06600 PHYSICAL THERAPY	270,058	0	66.00
69.00	06900 ELECTROCARDIOLOGY	25,043	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	213,979	0	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	67,244	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	694,676	757	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	539,889	0	90.00
90.01	09001 WOUND CARE	226,363	0	90.01
90.02	09002 CLINIC	0	0	90.02
91.00	09100 EMERGENCY	593,352	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	324,023	0	92.00
200.00	Subtotal (see instructions)	5,425,068	757	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	5,425,068	757	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/18/2015 4:11 pm PPS
		Title XVIII	Skilled Nursing Facility

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	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0	0	0	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WOUND CARE	0	0	0	0	90.01
90.02	09002	CLINIC	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/18/2015 4:11 pm PPS
		Title XVIII	Skilled Nursing Facility

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	4,334,542	0.000000	0.000000	0	50.00
52.00 05200 LABOR ROOM & DELIVERY ROOM	0	0	0.000000	0.000000	0	52.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	16,280,376	0.000000	0.000000	8,830	54.00
60.00 06000 LABORATORY	0	12,282,918	0.000000	0.000000	68,708	60.00
65.00 06500 RESPIRATORY THERAPY	0	2,488,989	0.000000	0.000000	33,622	65.00
66.00 06600 PHYSICAL THERAPY	0	3,190,789	0.000000	0.000000	336,585	66.00
69.00 06900 ELECTROCARDIOLOGY	0	1,458,092	0.000000	0.000000	714	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	5,416,797	0.000000	0.000000	151,061	71.00
72.00 07200 IMP. DEV CHARGED TO PATIENT	0	140,642	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	5,590,035	0.000000	0.000000	12,808	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	3,790,908	0.000000	0.000000	0	88.00
90.00 09000 CLINIC	0	1,260,654	0.000000	0.000000	0	90.00
90.01 09001 WOUND CARE	0	675,102	0.000000	0.000000	62	90.01
90.02 09002 CLINIC	0	0	0.000000	0.000000	0	90.02
91.00 09100 EMERGENCY	0	3,613,519	0.000000	0.000000	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	870,078	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	61,393,441			612,390	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part IV Date/Time Prepared: 11/18/2015 4:11 pm PPS
		Title XVIII	Skilled Nursing Facility

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
52.00 05200 LABOR ROOM & DELIVERY ROOM	0	0	0	52.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0	0	54.00
60.00 06000 LABORATORY	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMP. DEV CHARGED TO PATIENT	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0	0	88.00
90.00 09000 CLINIC	0	0	0	90.00
90.01 09001 WOUND CARE	0	0	0	90.01
90.02 09002 CLINIC	0	0	0	90.02
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: 141311 Component CCN: 145552	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/18/2015 4:11 pm PPS
		Title XVIII	Skilled Nursing Facility

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	0.382566	0	0	0	0	50.00
52.00 05200 LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0	0	52.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0.123357	0	0	0	0	54.00
60.00 06000 LABORATORY	0.212154	0	0	0	0	60.00
65.00 06500 RESPIRATORY THERAPY	0.163952	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.392655	0	0	0	0	66.00
69.00 06900 ELECTROCARDIOLOGY	0.055475	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181786	0	0	0	0	71.00
72.00 07200 IMP. DEV CHARGED TO PATIENT	0.509044	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.338023	0	0	40	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
90.00 09000 CLINIC	0.443024	0	0	0	0	90.00
90.01 09001 WOUND CARE	0.575566	0	0	0	0	90.01
90.02 09002 CLINIC	0.000000	0	0	0	0	90.02
91.00 09100 EMERGENCY	0.507466	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.968990	0	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	40	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	40	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/18/2015 4:11 pm
	Component CCN: 145552	Title XVIII	Skilled Nursing Facility PPS

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	0	0		50.00
52.00 05200 LABOR ROOM & DELIVERY ROOM	0	0		52.00
54.00 05400 RADIOLOGY - DIAGNOSTIC	0	0		54.00
60.00 06000 LABORATORY	0	0		60.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0		66.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00 07200 IMP. DEV CHARGED TO PATIENT	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	14		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
90.00 09000 CLINIC	0	0		90.00
90.01 09001 WOUND CARE	0	0		90.01
90.02 09002 CLINIC	0	0		90.02
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	14		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	14		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/18/2015 4:11 pm
	Title XIX	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	0.382566	0	0	0	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0.000000	0	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0.123357	0	0	0	54.00
60.00	06000 LABORATORY	0.212154	0	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.163952	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.392655	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.055475	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181786	0	0	0	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0.509044	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.338023	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	1.050604				88.00
90.00	09000 CLINIC	0.443024	0	0	0	90.00
90.01	09001 WOUND CARE	0.575566	0	0	0	90.01
90.02	09002 CLINIC	0.000000	0	0	0	90.02
91.00	09100 EMERGENCY	0.507466	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.968990	0	0	0	92.00
200.00	Subtotal (see instructions)		0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet D Part V Date/Time Prepared: 11/18/2015 4:11 pm
		Title XIX	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	0	0	50.00
52.00	05200 LABOR ROOM & DELIVERY ROOM	0	0	52.00
54.00	05400 RADIOLOGY - DIAGNOSTIC	0	0	54.00
60.00	06000 LABORATORY	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMP. DEV CHARGED TO PATIENT	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	0	0	90.00
90.01	09001 WOUND CARE	0	0	90.01
90.02	09002 CLINIC	0	0	90.02
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: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/18/2015 4:11 pm
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			2,999 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,999 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)			2,192 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 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)			1,719 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			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			188.27 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			192.90 20.00
21.00	Total general inpatient routine service cost (see instructions)			3,133,133 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			3,133,133 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			3,133,133 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)			1,044.73 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,795,891 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,795,891 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1	
Title XVIII		Hospital		Cost		Date/Time Prepared: 11/18/2015 4:11 pm	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	456,984	517	883.91	158	139,658		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,274,559		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,210,108		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)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						807	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,044.73	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						843,097	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/18/2015 4:11 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	329,458	3,133,133	0.105153	843,097	88,654	90.00
91.00	Nursing School cost	0	3,133,133	0.000000	843,097	0	91.00
92.00	Allied health cost	0	3,133,133	0.000000	843,097	0	92.00
93.00	All other Medical Education	0	3,133,133	0.000000	843,097	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1
		Component CCN: 145552		Date/Time Prepared: 11/18/2015 4:11 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		6,991	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,991	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)		6,991	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	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)		898	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		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		188.27	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		192.90	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,094,775	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,094,775	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,094,775	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)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1	
		Component CCN: 145552		Date/Time Prepared: 11/18/2015 4:11 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				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)				50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				54.00
55.00	Target amount per discharge				55.00
56.00	Target amount (line 54 x line 55)				56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				57.00
58.00	Bonus payment (see instructions)				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				59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				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)				61.00
62.00	Relief payment (see instructions)				62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				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)				64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				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)				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)				68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				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)			2,094,775	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)			299.64	71.00
72.00	Program routine service cost (line 9 x line 71)			269,077	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)			0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)			269,077	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)			0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)			0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)			0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)			0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)			0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)			0	80.00
81.00	Inpatient routine service cost per diem limitation			0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)			0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)			269,077	83.00
84.00	Program inpatient ancillary services (see instructions)			185,206	84.00
85.00	Utilization review - physician compensation (see instructions)			0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)			454,283	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)			0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)			0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311 Component CCN: 145552		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/18/2015 4:11 pm	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital -related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/18/2015 4:11 pm
Cost Center Description		Title XIX	Hospital	Cost
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,999	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,999	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)		2,192	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	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)		192	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		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		188.27	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		192.90	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,133,133	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3,133,133	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		3,133,133	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)		1,044.73	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		200,588	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)		200,588	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1	
Date/Time Prepared: 11/18/2015 4:11 pm		Title XIX		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)		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	456,984	517	883.91	21	18,562		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						219,150	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)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						807	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,044.73	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						843,097	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141311		Period: From 07/01/2014 To 06/30/2015		Worksheet D-1 Date/Time Prepared: 11/18/2015 4:11 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	329,458	3,133,133	0.105153	843,097	88,654	90.00
91.00	Nursing School cost	0	3,133,133	0.000000	843,097	0	91.00
92.00	Allied health cost	0	3,133,133	0.000000	843,097	0	92.00
93.00	All other Medical Education	0	3,133,133	0.000000	843,097	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 11/18/2015 4:11 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		1,781,690	30.00
31.00	03100	INTENSIVE CARE UNIT		325,090	31.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.382566	288,703	110,448 50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000	0	0 52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.123357	965,140	119,057 54.00
60.00	06000	LABORATORY	0.212154	1,303,178	276,474 60.00
65.00	06500	RESPIRATORY THERAPY	0.163952	502,935	82,457 65.00
66.00	06600	PHYSICAL THERAPY	0.392655	175,203	68,794 66.00
69.00	06900	ELECTROCARDIOLOGY	0.055475	174,136	9,660 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181786	1,147,554	208,609 71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.509044	5,514	2,807 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338023	881,901	298,103 73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
90.00	09000	CLINIC	0.443024	0	0 90.00
90.01	09001	WOUND CARE	0.575566	2,390	1,376 90.01
90.02	09002	CLINIC	0.000000	0	0 90.02
91.00	09100	EMERGENCY	0.507466	66,864	33,931 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.968990	64,854	62,843 92.00
200.00		Total (sum of lines 50-94 and 96-98)		5,578,372	1,274,559 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0 201.00
202.00		Net Charges (line 200 minus line 201)		5,578,372	1,274,559 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 11/18/2015 4:11 pm	
		Title XVIII	Skilled Nursing Facility	PPS	
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
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.382566	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.123357	8,830	54.00
60.00	06000	LABORATORY	0.212154	68,708	60.00
65.00	06500	RESPIRATORY THERAPY	0.163952	33,622	65.00
66.00	06600	PHYSICAL THERAPY	0.392655	336,585	66.00
69.00	06900	ELECTROCARDIOLOGY	0.055475	714	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181786	151,061	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.509044	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338023	12,808	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.443024	0	90.00
90.01	09001	WOUND CARE	0.575566	62	90.01
90.02	09002	CLINIC	0.000000	0	90.02
91.00	09100	EMERGENCY	0.507466	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.968990	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		612,390	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)		612,390	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet D-3 Date/Time Prepared: 11/18/2015 4:11 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		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.382566	0	50.00
52.00	05200	LABOR ROOM & DELIVERY ROOM	0.000000	0	52.00
54.00	05400	RADIOLOGY - DIAGNOSTIC	0.123357	0	54.00
60.00	06000	LABORATORY	0.212154	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.163952	0	65.00
66.00	06600	PHYSICAL THERAPY	0.392655	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.055475	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.181786	0	71.00
72.00	07200	IMP. DEV CHARGED TO PATIENT	0.509044	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.338023	0	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	1.050604	0	88.00
90.00	09000	CLINIC	0.443024	0	90.00
90.01	09001	WOUND CARE	0.575566	0	90.01
90.02	09002	CLINIC	0.000000	0	90.02
91.00	09100	EMERGENCY	0.507466	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.968990	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		0	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)		0	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/18/2015 4:11 pm
		Title XVIII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		5,425,825	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)		5,425,825	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)		5,480,083	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)		98,512	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,292,791	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)		2,088,780	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)		2,088,780	30.00
31.00	Primary payer payments		542	31.00
32.00	Subtotal (line 30 minus line 31)		2,088,238	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)		959,962	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		729,571	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		911,896	36.00
37.00	Subtotal (see instructions)		2,817,809	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)		2,817,809	40.00
40.01	Sequestration adjustment (see instructions)		56,356	40.01
41.00	Interim payments		2,850,382	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-88,929	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		131,316	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/18/2015 4:11 pm
		Component CCN: 145552	Title XVIII	Skilled Nursing Facility PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		14	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			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)		14	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		40	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)		40	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)		40	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		26	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)		14	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)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			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)		14	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)		14	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		14	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)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		14	37.00
38.00	MSP-LCC reconciliation amount from PS&R			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)		14	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
41.00	Interim payments		10	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		4	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)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141311

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

Worksheet E-1
Part I
Date/Time Prepared:
11/18/2015 4:11 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		2,433,147		2,850,382		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	02/15/2015	222,600		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)		222,600		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,655,747		2,850,382		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		17,626		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		88,929		6.02
7.00	Total Medicare program liability (see instructions)		2,673,373		2,761,453		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: 141311
Component CCN: 145552

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

Worksheet E-1
Part I
Date/Time Prepared:
11/18/2015 4:11 pm
PPS

Title XVIII

Skilled Nursing
Facility

		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		285,320			10 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)		285,320			10 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			4 6.01
6.02	SETTLEMENT TO PROGRAM		0			0 6.02
7.00	Total Medicare program liability (see instructions)		285,320			14 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 141311

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

Worksheet E-1
Part II
Date/Time Prepared:
11/18/2015 4:11 pm

Title XVIII

Hospital

Cost

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	799	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,877	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,709	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	68,057,957	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	108,211	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	915,314	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	818,291	8.00
9.00	Sequestration adjustment amount (see instructions)	16,366	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	801,925	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)	847,201	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-45,276	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part V Date/Time Prepared: 11/18/2015 4:11 pm
		Title XVIII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			3,210,108 1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0 2.00
3.00	Organ acquisition			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			3,210,108 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3,242,209 6.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
7.00	Routine service charges			0 7.00
8.00	Ancillary service charges			0 8.00
9.00	Organ acquisition charges, net of revenue			0 9.00
10.00	Total reasonable charges			0 10.00
Customary charges				
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000 13.00
14.00	Total customary charges (see instructions)			0 14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			0 15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)			0 16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)			0 17.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			3,242,209 19.00
20.00	Deductibles (exclude professional component)			589,038 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			2,653,171 22.00
23.00	Coinsurance			912 23.00
24.00	Subtotal (line 22 minus line 23)			2,652,259 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			99,570 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			75,673 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			91,468 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2,727,932 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)			2,727,932 30.00
30.01	Sequestration adjustment (see instructions)			54,559 30.01
31.00	Interim payments			2,655,747 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)			17,626 33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			77,697 34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141311 Component CCN: 145552	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VI Date/Time Prepared: 11/18/2015 4:11 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		330,693	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		330,693	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		5,958	6.00
7.00	Coinsurance		33,592	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		291,143	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (see instructions)		291,143	15.00
15.01	Sequestration adjustment (see instructions)		5,823	15.01
16.00	Interim payments		285,320	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 141311

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

Worksheet G

Date/Time Prepared:
11/18/2015 4:11 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	609,126	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	13,828,636	0	0	0	4.00
5.00	Other receivable	802,457	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,807,073	0	0	0	6.00
7.00	Inventory	323,720	0	0	0	7.00
8.00	Prepaid expenses	285,501	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	7,042,367	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	37,385,416	0	0	0	15.00
16.00	Accumulated depreciation	-21,431,917	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	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)	15,953,499	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	1,761	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	1,172,379	0	0	0	33.00
34.00	Other assets	503,637	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,677,777	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	24,673,643	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	1,308,491	0	0	0	37.00
38.00	Salaries, wages, and fees payable	404,288	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	584,144	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	0	0	0	0	43.00
44.00	Other current liabilities	831,376	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	3,128,299	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	6,719,685	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	6,719,685	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	9,847,984	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	14,825,659	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	14,825,659	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	24,673,643	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141311

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

Worksheet G-1

Date/Time Prepared:
11/18/2015 4:11 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		13,992,598		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		833,061			2.00
3.00	Total (sum of line 1 and line 2)		14,825,659		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00		0		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)		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		14,825,659		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		14,825,659		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	Additions (credit adjustments) (specify)		0			4.00
5.00			0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	Deductions (debit adjustments) (specify)		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 141311

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/18/2015 4:11 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,489,916		5,489,916	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,004,498		1,004,498	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	6,494,414		6,494,414	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	467,519		467,519	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)	467,519		467,519	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	6,961,933		6,961,933	17.00
18.00	Ancillary services	9,152,781	46,319,020	55,471,801	18.00
19.00	Outpatient services	0	1,260,654	1,260,654	19.00
20.00	RURAL HEALTH CLINIC	0	3,790,908	3,790,908	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		572,661	572,661	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	PRO FEES	349,812	5,902,837	6,252,649	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	16,464,526	57,846,080	74,310,606	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		27,677,854		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	WAYFAIR	132,797			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)		132,797		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		27,545,057		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141311

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

Worksheet G-3

Date/Time Prepared:
11/18/2015 4:11 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	74,310,606	1.00
2.00	Less contractual allowances and discounts on patients' accounts	46,933,365	2.00
3.00	Net patient revenues (line 1 minus line 2)	27,377,241	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	27,545,057	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-167,816	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER REVENUE	824,885	24.00
24.01	NON OPERATING REVENUE	175,992	24.01
24.02		0	24.02
25.00	Total other income (sum of lines 6-24)	1,000,877	25.00
26.00	Total (line 5 plus line 25)	833,061	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	833,061	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 141311

Period: From 07/01/2014

Worksheet H

HHA CCN: 147612

To 06/30/2015

Date/Time Prepared: 11/18/2015 4:11 pm

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	29,653	0	32,875	5,263	30,986	98,777	5.00
HHA REIMBURSABLE SERVICES							
6.00	144,239	0	0	0	0	144,239	6.00
7.00	0	0	0	0	0	0	7.00
8.00	0	0	0	0	0	0	8.00
9.00	0	0	0	0	0	0	9.00
10.00	0	0	0	0	0	0	10.00
11.00	0	0	0	0	0	0	11.00
12.00	0	0	0	0	0	0	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	82,298	0	0	0	0	82,298	23.00
24.00	256,190	0	32,875	5,263	30,986	325,314	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	0	98,777	0	98,777			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	144,239	0	144,239			6.00
7.00	0	0	0	0			7.00
8.00	0	0	0	0			8.00
9.00	0	0	0	0			9.00
10.00	0	0	0	0			10.00
11.00	0	0	0	0			11.00
12.00	0	0	0	0			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	82,298	0	82,298			23.00
24.00	0	325,314	0	325,314			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 141311	Period: 07/01/2014	Worksheet H-1
		HHA CCN: 147612	To 06/30/2015	Part I
				Date/Time Prepared: 11/18/2015 4:11 pm
			Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		Bl dgs & Fixtures	Movable Equipment				
		1.00	2.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00
2.00	Capital Related - Movable Equipment	0	0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	98,777	0	0	0	98,777	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	144,239	0	0	0	144,239	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	DIRECTOR	82,298	0	0	0	82,298	23.00
24.00	Total (sum of lines 1-23)	325,314	0	0	0	325,314	24.00
		Administrative & General	Total (cols. 4A + 5)				
		5.00	6.00				
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures						1.00
2.00	Capital Related - Movable Equipment						2.00
3.00	Plant Operation & Maintenance						3.00
4.00	Transportation						4.00
5.00	Administrative and General	98,777					5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	62,893	207,132				6.00
7.00	Physical Therapy	0	0				7.00
8.00	Occupational Therapy	0	0				8.00
9.00	Speech Pathology	0	0				9.00
10.00	Medical Social Services	0	0				10.00
11.00	Home Health Aide	0	0				11.00
12.00	Supplies (see instructions)	0	0				12.00
13.00	Drugs	0	0				13.00
14.00	DME	0	0				14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0				15.00
16.00	Respiratory Therapy	0	0				16.00
17.00	Private Duty Nursing	0	0				17.00
18.00	Clinic	0	0				18.00
19.00	Health Promotion Activities	0	0				19.00
20.00	Day Care Program	0	0				20.00
21.00	Home Delivered Meals Program	0	0				21.00
22.00	Homemaker Service	0	0				22.00
23.00	DIRECTOR	35,884	118,182				23.00
24.00	Total (sum of lines 1-23)		325,314				24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 141311
HHA CCN: 147612

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

Worksheet H-1
Part II
Date/Time Prepared:
11/18/2015 4:11 pm
PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-98,777	226,537
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	144,239	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	DIRECTOR	0	0	0	0	82,298	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-98,777	226,537
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	98,777	98,777
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.436030

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141311

Period: From 07/01/2014

Worksheet H-2

HHA CCN: 147612

To 06/30/2015

Part I
Date/Time Prepared:
11/18/2015 4:11 pm

Home Health
Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				
1.00 Administrative and General	0	22,696	9,616	6,944	39,256	6,312	1.00
2.00 Skilled Nursing Care	207,132	0	0	33,778	240,910	38,738	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 DIRECTOR	118,182	0	0	19,272	137,454	22,102	19.00
20.00 Total (sum of lines 1-19) (2)	325,314	22,696	9,616	59,994	417,620	67,152	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
	6.00	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	20,611	17,380	0	17,150	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 DIRECTOR	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	20,611	17,380	0	17,150	0	0	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 141311

Period: From 07/01/2014

Worksheet H-2

HHA CCN: 147612

To 06/30/2015

Part I
Date/Time Prepared: 11/18/2015 4:11 pm

Home Health Agency I

PPS

Cost Center Description		NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		13.00	16.00	17.00	24.00	25.00	26.00	
1.00	Administrative and General	0	0	0	100,709	0	100,709	1.00
2.00	Skilled Nursing Care	0	0	0	279,648	0	279,648	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	DIRECTOR	0	0	0	159,556	0	159,556	19.00
20.00	Total (sum of lines 1-19) (2)	0	0	0	539,913	0	539,913	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs					
		27.00	28.00					
1.00	Administrative and General							
2.00	Skilled Nursing Care	64,123	343,771					
3.00	Physical Therapy	0	0					
4.00	Occupational Therapy	0	0					
5.00	Speech Pathology	0	0					
6.00	Medical Social Services	0	0					
7.00	Home Health Aide	0	0					
8.00	Supplies (see instructions)	0	0					
9.00	Drugs	0	0					
10.00	DME	0	0					
11.00	Home Dialysis Aide Services	0	0					
12.00	Respiratory Therapy	0	0					
13.00	Private Duty Nursing	0	0					
14.00	Clinic	0	0					
15.00	Health Promotion Activities	0	0					
16.00	Day Care Program	0	0					
17.00	Home Delivered Meals Program	0	0					
18.00	Homemaker Service	0	0					
19.00	DIRECTOR	36,586	196,142					
20.00	Total (sum of lines 1-19) (2)	100,709	539,913					
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.229299						

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141311
HHA CCN: 147612

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

Worksheet H-2 Part II
Date/Time Prepared: 11/18/2015 4:11 pm
PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)					
	1.00	2.00					
1.00 Administrative and General	1,920	1,920	29,653	0	39,256	1,920	1.00
2.00 Skilled Nursing Care	0	0	144,239	0	240,910	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 DIRECTOR	0	0	82,298	0	137,454	0	19.00
20.00 Total (sum of lines 1-19)	1,920	1,920	256,190		417,620	1,920	20.00
21.00 Total cost to be allocated	22,696	9,616	59,994		67,152	20,611	21.00
22.00 Unit cost multiplier	11.820833	5.008333	0.234178		0.160797	10.734896	22.00
Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PAID HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
	7.00	8.00	9.00	10.00	11.00	13.00	
1.00 Administrative and General	1,920	0	1,920	0	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 DIRECTOR	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	1,920	0	1,920	0	0	0	20.00
21.00 Total cost to be allocated	17,380	0	17,150	0	0	0	21.00
22.00 Unit cost multiplier	9.052083	0.000000	8.932292	0.000000	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 141311
HHA CCN: 147612

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

Worksheet H-2
Part II
Date/Time Prepared:
11/18/2015 4:11 pm
PPS

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

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet H-3 Part I Date/Time Prepared: 11/18/2015 4:11 pm	
				HHA CCN: 147612	Title XVIII Home Health Agency I		PPS
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
	0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	343,771		343,771	2,334	147.29
2.00	Physical Therapy	3.00	0	0	0	959	0.00
3.00	Occupational Therapy	4.00	0	0	0	205	0.00
4.00	Speech Pathology	5.00	0	0	0	13	0.00
5.00	Medical Social Services	6.00	0	0	0	0	0.00
6.00	Home Health Aide	7.00	0	0	0	15	0.00
7.00	Total (sum of lines 1-6)		343,771	0	343,771	3,526	
Program Visits							
Part B							
Not Subject to Deductibles & Coinsurance							
Subject to Deductibles							
Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits			
	0	1.00	2.00	3.00		4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care		14999	0	1,804		8.00
9.00	Physical Therapy		14999	0	661		9.00
10.00	Occupational Therapy		14999	0	160		10.00
11.00	Speech Pathology		14999	0	9		11.00
12.00	Medical Social Services		14999	0	0		12.00
13.00	Home Health Aide		14999	0	8		13.00
14.00	Total (sum of lines 8-13)			0	2,642		14.00
Cost Center Description							
From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)		
0	1.00	2.00	3.00	4.00	5.00		
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000
Program Visits							
Part B							
Not Subject to Deductibles & Coinsurance							
Subject to Deductibles & Coinsurance							
Cost Center Description	Part A	Part B	Part A	Part B	Part A	Part B	Part B
	6.00	7.00	8.00	9.00	10.00	11.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	1,804		0	265,711	1.00
2.00	Physical Therapy	0	661		0	0	2.00
3.00	Occupational Therapy	0	160		0	0	3.00
4.00	Speech Pathology	0	9		0	0	4.00
5.00	Medical Social Services	0	0		0	0	5.00
6.00	Home Health Aide	0	8		0	0	6.00
7.00	Total (sum of lines 1-6)	0	2,642		0	265,711	7.00
Cost Center Description							
	6.00	7.00	8.00	9.00	10.00	11.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 141311 HHA CCN: 147612	Period: From 07/01/2014 To 06/30/2015	Worksheet H-3 Part I Date/Time Prepared: 11/18/2015 4:11 pm PPS
		Title XVII I	Home Health Agency I	

Cost Center Description	Program Covered Charges			Cost of Services	Part B	Subject to Deductibles & Coinsurance		
	Part A	Part B						
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance					
	6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	0	0	0	0	15.00	
16.00	Cost of Drugs		0	0	0	0	16.00	
Cost Center Description		Total Program Cost (sum of col.s. 9-10)						
		12.00						
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	265,711						1.00
2.00	Physical Therapy	0						2.00
3.00	Occupational Therapy	0						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	0						5.00
6.00	Home Health Aide	0						6.00
7.00	Total (sum of lines 1-6)	265,711						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 141311 HHA CCN: 147612	Period: From 07/01/2014 To 06/30/2015	Worksheet H-3 Part II Date/Time Prepared: 11/18/2015 4:11 pm PPS
		Title XVIII	Home Health Agency I	

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.392655	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy					2.00
3.00	Speech Pathology					3.00
4.00	Cost of Medical Supplies	71.00	0.181786	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.338023	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 141311 HHA CCN: 147612	Period: From 07/01/2014 To 06/30/2015	Worksheet H-4 Part I-11 Date/Time Prepared: 11/18/2015 4:11 pm
		Title XVII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	334,786
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	22,142
13.00	Total PPS Reimbursement - LUPA Episodes		0	8,990
14.00	Total PPS Reimbursement - PEP Episodes		0	1,134
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	14,780
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	381,832
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	381,832
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	381,832
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	381,832
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	381,832
31.01	Sequestration adjustment (see instructions)		0	7,485
32.00	Interim payments (see instructions)		0	374,196
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	151
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

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

Provider CCN: 141311
HHA CCN: 147612

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

Worksheet H-5
Date/Time Prepared:
11/18/2015 4:11 pm
PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		374,196	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		374,196	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		151	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		374,347	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2014 To 06/30/2015	Worksheet M-1 Date/Time Prepared: 11/18/2015 4:11 pm
		Rural Health Clinic (RHC) I	Cost

	Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassified	Reclassified Trial Balance (col. 3 + col. 4)	
	1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	1,065,132	0	1,065,132	0	1,065,132 1.00
2.00	Physician Assistant	182,007	0	182,007	0	182,007 2.00
3.00	Nurse Practitioner	13,713	0	13,713	0	13,713 3.00
4.00	Visiting Nurse	0	0	0	0	0 4.00
5.00	Other Nurse	0	0	0	0	0 5.00
6.00	Clinical Psychologist	0	0	0	0	0 6.00
7.00	Clinical Social Worker	0	0	0	0	0 7.00
8.00	Laboratory Technician	0	0	0	0	0 8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0 9.00
10.00	Subtotal (sum of lines 1 through 9)	1,260,852	0	1,260,852	0	1,260,852 10.00
11.00	Physician Services Under Agreement	0	0	0	0	0 11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0 12.00
13.00	Other Costs Under Agreement	0	0	0	0	0 13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0 14.00
15.00	Medical Supplies	0	0	0	0	0 15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0 16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0 17.00
18.00	Professional Liability Insurance	0	0	0	0	0 18.00
19.00	Other Health Care Costs	0	0	0	0	0 19.00
20.00	Allowable GME Costs	0	0	0	0	0 20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0 21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,260,852	0	1,260,852	0	1,260,852 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	0	0	0	0 26.00
27.00	Nonallowable GME costs	0	0	0	0	0 27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0 28.00
FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0 29.00
30.00	Administrative Costs	723,099	267,882	990,981	0	990,981 30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	723,099	267,882	990,981	0	990,981 31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,983,951	267,882	2,251,833	0	2,251,833 32.00

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

Provider CCN: 141311
Component CCN: 148500

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

Worksheet M-1
Date/Time Prepared:
11/18/2015 4:11 pm
Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	1,065,132	1.00
2.00	Physician Assistant	0	182,007	2.00
3.00	Nurse Practitioner	0	13,713	3.00
4.00	Visiting Nurse	0	0	4.00
5.00	Other Nurse	0	0	5.00
6.00	Clinical Psychologist	0	0	6.00
7.00	Clinical Social Worker	0	0	7.00
8.00	Laboratory Technician	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,260,852	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	0	0	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,260,852	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	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD				
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	990,981	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	990,981	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,251,833	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2014 To 06/30/2015	Worksheet M-2 Date/Time Prepared: 11/18/2015 4:11 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	3.35	12,610	4,200	14,070	1.00
2.00	Physician Assistant	1.71	0	2,100	3,591	2.00
3.00	Nurse Practitioner	0.03	5,649	2,100	63	3.00
4.00	Subtotal (sum of lines 1 through 3)	5.09	18,259		17,724	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)	5.09	18,259		18,259	8.00
9.00	Physician Services Under Agreements		0		0	9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES			
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)		1,260,852 10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		0 11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)		1,260,852 12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)		1.000000 13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)		990,981 14.00
15.00	Parent provider overhead allocated to facility (see instructions)		1,730,911 15.00
16.00	Total overhead (sum of lines 14 and 15)		2,721,892 16.00
17.00	Allowable GME overhead (see instructions)		0 17.00
18.00	Subtotal (see instructions)		2,721,892 18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)		2,721,892 19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		3,982,744 20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141311	Period: From 07/01/2014 To 06/30/2015	Worksheet M-3
		Component CCN: 148500		Date/Time Prepared: 11/18/2015 4:11 pm
		Title XVIIII	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)		3,982,744	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		125,455	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		3,857,289	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		18,259	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)		18,259	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		211.25	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)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	211.25	211.25	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	6,102	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,289,048	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) *		1,289,048	16.00
16.01	Total program charges (see instructions)(from contractor's records)		672,239	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		197	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		378	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.)		965,826	16.04
16.05	Total program cost (see instructions)		966,204	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		81,388	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		118,131	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		966,204	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		86,168	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,052,372	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)		1,052,372	26.00
26.01	Sequestration adjustment (see instructions)		21,047	26.01
27.00	Interim payments		974,921	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)		56,404	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		26,801	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2014 To 06/30/2015	Worksheet M-4 Date/Time Prepared: 11/18/2015 4:11 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)	1,260,852	1,260,852	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001800	0.004100	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	2,270	5,169	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	23,389	8,888	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	25,659	14,057	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,260,852	1,260,852	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	2,721,892	2,721,892	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.020351	0.011149	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	55,393	30,346	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	81,052	44,403	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	191	428	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	424.36	103.75	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	150	217	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	63,654	22,514	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)		125,455	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)		86,168	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141311 Component CCN: 148500	Period: From 07/01/2014 To 06/30/2015	Worksheet M-5 Date/Time Prepared: 11/18/2015 4:11 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		921,521	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		02/15/2015	53,400	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)		53,400	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		974,921	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		56,404	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,031,325	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00
8.00	Name of Contractor			8.00