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: 141317	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/23/2016 7:53 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/23/2016 Time: 7:53 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GIBSON AREA HOSPITAL AND HEALTH SVCS (141317) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	615,435	-2,365	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	34,624	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	-7		0	7.00
10.00	RURAL HEALTH CLINIC I	0		518,692		0	10.00
10.01	RURAL HEALTH CLINIC (RHC) II	0		2,145		0	10.01
200.00	Total	0	650,059	518,465	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 2/23/2016 6:02 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1120 N. MELVIN	PO Box:			1.00
2.00	City: GIBSON CITY	State: IL	Zip Code: 60936-	County: FORD	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	GIBSON AREA HOSPITAL AND HEALTH SVCS	141317	99914	1	01/03/2002	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	GIBSON COMMUNITY SWING BEDS	14Z317	99914		12/31/2002	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GIBSON HOSPITAL ANNEX SNF	145979	99914		05/19/1999	N	P	P	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	THE PAXTON CLINIC	143408	99914		01/01/1996	N	O	O	15.00
15.01	Hospital-Based Health Clinic - RHC II	GIBSON AREA MEDICAL CLINIC	148546	99914		06/10/2015	N	O	O	15.01
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: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2014	09/30/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 6:02 pm

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

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

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 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	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N			60.00

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

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

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

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N	63.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 6:02 pm

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

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, 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

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		1.00	2.00	3.00	
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, 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.		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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/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
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	760,834	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
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 2/23/2016 6:02 pm

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

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

			1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under §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)		0	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)	04/01/2015	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: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2016 6:02 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	Y			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

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	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)		Y	02/11/2016	Y	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: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2016 6:02 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	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.				Y	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.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404	DAN.LINHART@RSMUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 2/23/2016 6:02 pm

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)				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)	02/11/2016			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.		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: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 2/23/2016 6:02 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	23	8,395	56,088.00	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)		23	8,395	56,088.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	2	730	1,464.00	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	57,552.00	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	5	1,825		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	46.00	37	13,505			21.00
22.00	HOME HEALTH AGENCY						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	RHC (CONSOLIDATED)	88.00				0	26.00
26.01	RURAL HEALTH CLINIC (RHC)	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		67				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: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2016 6:02 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,013	215	2,244			1.00
2.00	HMO and other (see instructions)	351	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	454	0	600			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	36			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,467	215	2,880			7.00
8.00	INTENSIVE CARE UNIT	43	1	61			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		113	317			13.00
14.00	Total (see instructions)	1,510	329	3,258	0.00	490.63	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	569	0	585	0.00	1.57	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE			11,889	0.00	31.88	21.00
22.00	HOME HEALTH AGENCY						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	RHC (CONSOLIDATED)	7,068	0	36,685	0.00	80.97	26.00
26.01	RURAL HEALTH CLINIC (RHC)	139	0	1,806	0.00	0.89	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	605.94	27.00
28.00	Observation Bed Days		0	383			28.00
29.00	Ambulance Trips	903					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)			93			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 2/23/2016 6:02 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	330	93	763	1.00
2.00	HMO and other (see instructions)			100	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	330	93	763	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						20.00
21.00	OTHER LONG TERM CARE	0.00				79	21.00
22.00	HOME HEALTH AGENCY						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	RHC (CONSOLIDATED)	0.00					26.00
26.01	RURAL HEALTH CLINIC (RHC)	0.00					26.01
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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-7 | Date/Time Prepared: 2/23/2016 6:02 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.	Y	12/31/2002	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	13	0	13	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	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	28	0	28	16.00
17.00		RVA	69	0	69	17.00
18.00		RHC	70	0	70	18.00
19.00		RHB	40	0	40	19.00
20.00		RHA	218	0	218	20.00
21.00		RMC	35	0	35	21.00
22.00		RMB	9	0	9	22.00
23.00		RMA	37	0	37	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	0	0	0	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	0	0	0	33.00
34.00		HC1	6	0	6	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	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	0	0	0	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	8	0	8	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	8	0	8	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: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-7 | Date/Time Prepared: 2/23/2016 6:02 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	15	0	15	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	6	0	6	78.00
199.00		AAA	4	0	4	199.00
200.00	TOTAL		569	0	569	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	
	SNF SERVICES			
201.00	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).	16580	16580	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	69,688	40.45	Y	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)	172,267			207.00

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

Provider CCN: 141317 Component CCN: 143408 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-8 | Date/Time Prepared: 2/23/2016 6:02 pm

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	225 MARKET STREET	1.00
	City	State	ZIP Code
	1.00	2.00	3.00
2.00	City, State, ZIP Code, County	PAXTON IL	60957 2.00
			1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0 3.00
		Grant Award	Date
		1.00	2.00
	Source of Federal Funds		
4.00	Community Health Center (Section 330(d), PHS Act)	0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0	6.00
7.00	Appalachian Regional Commission	0	7.00
8.00	Look-Alikes	0	8.00
9.00	OTHER (SPECIFY)	0	9.00
		1.00	2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0 10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:00	17:00	07:00	11.00

		1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?	N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.	Y	6	13.00

		Provider name	CCN number	
		1.00	2.00	
14.00	Provider name, CCN number	THE PAXTON CLINIC	143408	14.00
14.01		THE ONARGA CLINIC	143440	14.01
14.02		PRAIRIE FAMILY MEDICINE & OBSTETRI	148505	14.02
14.03		HOOPESTON CLINIC	148515	14.03
14.04		FARMER CITY CLINIC	148517	14.04
14.05		GIBSON CITY CLINIC	148516	14.05

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

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

Provider CCN: 141317
Component CCN: 143408

Period: From 10/01/2014 To 09/30/2015

Worksheet S-8
Date/Time Prepared: 2/23/2016 6:02 pm

Rural Health Clinic (RHC) I

Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		FORD				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	07:00	17:00	07:00	17:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	07:00	17:00				11.00

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

Provider CCN: 141317 Component CCN: 148546 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-8 | Date/Time Prepared: 2/23/2016 6:02 pm

		Rural Health Clinic (RHC) II	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	109 NORTH CHESNUT	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	ONARGA	IL	60955	2.00

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	16:00	07:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County		IROGUOIS				2.00

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	19:00	07:00	19:00	07:00	19:00	11.00

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

Provider CCN: 141317
Component CCN: 148546

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-8

Date/Time Prepared:
2/23/2016 6:02 pm

Rural Health Clinic (RHC) II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	16:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet S-10 | Date/Time Prepared: 2/23/2016 6:02 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.408679	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,441,286	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	437,804	5.00
6.00	Medicaid charges	10,947,436	6.00
7.00	Medicaid cost (line 1 times line 6)	4,473,987	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)	1,594,897	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	110,629	9.00
10.00	Stand-alone SCHIP charges	441,126	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	180,279	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	69,650	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)	1,664,547	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	1,183,515	1,331,000	2,514,515	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	483,678	543,952	1,027,630	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)	483,678	543,952	1,027,630	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)	3,086,709	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	172,330	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	2,914,379	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,191,045	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	2,218,675	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,883,222	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/23/2016 6:02 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		2,591,900	2,591,900	-1,248,598	1,343,302	1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT		0	0	263,205	263,205	1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	1,099,502	1,099,502	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	330,673	9,731,667	10,062,340	244,619	10,306,959	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	1,292,439	827,520	2,119,959	-77,417	2,042,542	5.01
5.02	00591	ALL OTHER ADMIN & GENERAL	3,965,671	7,453,097	11,418,768	-636,347	10,782,421	5.02
7.00	00700	OPERATION OF PLANT	423,142	1,225,703	1,648,845	-152,392	1,496,453	7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY	67,764	31,925	99,689	158,235	257,924	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	122,177	46,773	168,950	0	168,950	8.00
9.00	00900	HOUSEKEEPING	368,226	91,873	460,099	0	460,099	9.00
10.00	01000	DIETARY	478,873	420,241	899,114	-526,858	372,256	10.00
11.00	01100	CAFETERIA	0	0	0	526,858	526,858	11.00
13.00	01300	NURSING ADMINISTRATION	490,472	150,885	641,357	-18,326	623,031	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	97,315	97,315	0	97,315	14.00
15.00	01500	PHARMACY	471,071	111,031	582,102	0	582,102	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	282,840	95,815	378,655	0	378,655	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,971,902	356,817	3,328,719	-26,628	3,302,091	30.00
31.00	03100	INTENSIVE CARE UNIT	637,391	11,564	648,955	-427,147	221,808	31.00
43.00	04300	NURSERY	0	0	0	350,846	350,846	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	76,955	76,955	44.00
46.00	04600	OTHER LONG TERM CARE	1,485,960	249,953	1,735,913	-171,950	1,563,963	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,640,700	1,007,785	2,648,485	0	2,648,485	50.00
51.00	05100	RECOVERY ROOM	285,539	36,446	321,985	0	321,985	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	102,929	102,929	52.00
53.00	05300	ANESTHESIOLOGY	1,238,520	881,797	2,120,317	15,762	2,136,079	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,547,366	2,223,119	3,770,485	-107,020	3,663,465	54.00
56.00	05600	RADIOISOTOPE	0	119,698	119,698	108,787	228,485	56.00
60.00	06000	LABORATORY	841,455	1,031,814	1,873,269	0	1,873,269	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	113,410	113,410	0	113,410	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	413,644	78,931	492,575	-31,102	461,473	65.00
66.00	06600	PHYSICAL THERAPY	1,247,945	104,382	1,352,327	57,033	1,409,360	66.00
67.00	06700	OCCUPATIONAL THERAPY	148,705	7,379	156,084	0	156,084	67.00
68.00	06800	SPEECH PATHOLOGY	330	35,875	36,205	0	36,205	68.00
69.00	06900	ELECTROCARDIOLOGY	0	261,623	261,623	31,102	292,725	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	848,783	848,783	0	848,783	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,693,148	2,693,148	0	2,693,148	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,128,197	1,128,197	0	1,128,197	73.00
73.01	07301	CARDIAC REHAB	134,823	15,844	150,667	0	150,667	73.01
73.02	07302	WOUND CARE	197,117	24,035	221,152	8,814	229,966	73.02
73.03	07303	SLEEP LAB	104,048	100,062	204,110	0	204,110	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	68,263	68,263	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	6,479,348	3,036,234	9,515,582	399,383	9,914,965	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	77,539	44,962	122,501	430	122,931	88.01
90.00	09000	CLINIC	214,802	35,774	250,576	0	250,576	90.00
90.01	09001	GERI PSYCH CLINIC	176,853	196,948	373,801	0	373,801	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,284,266	1,992,843	3,277,109	0	3,277,109	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,812,213	246,010	2,058,223	156,170	2,214,393	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	31,233,814	39,759,178	70,992,992	245,108	71,238,100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.01	19201	GAH - MSO	196,347	153,044	349,391	0	349,391	192.01
192.02	19202	GAH FOUNDATION	40,642	179,425	220,067	0	220,067	192.02
194.00	07950	FALCON POINT RENTAL	0	0	0	7,301	7,301	194.00
194.01	07951	PHYSICIAN OFFICE	595,534	186,802	782,336	-42,842	739,494	194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	698,658	182,800	881,458	-25,784	855,674	194.02
194.03	07953	WELLNESS CENTER	133,444	25,864	159,308	16,617	175,925	194.03
194.04	07954	PSYCH CLINIC	175,361	292,466	467,827	-7,988	459,839	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	171,044	127,218	298,262	28,865	327,127	194.05
194.06	07956	LASER CLINIC	0	7,024	7,024	0	7,024	194.06
194.07	07957	PAIN CLINIC	4,901	47,443	52,344	0	52,344	194.07
194.08	07958	340B PHARMACY	0	371,901	371,901	0	371,901	194.08
194.09	07959	GAH CARDIOLOGY	770,810	166,212	937,022	-68,354	868,668	194.09
194.10	07960	WIC	220,237	17,942	238,179	0	238,179	194.10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/23/2016 6:02 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	
194.11	07961	PULMONARY CLINIC	0	632	632	0	632	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	121,665	44,772	166,437	-295	166,142	194.12
194.13	07963	PODIATRY	96,416	14,208	110,624	-7,160	103,464	194.13
194.14	07964	9TH STREET CLINIC	16,486	14,552	31,038	-1,341	29,697	194.14
194.15	07965	ORTHO CLINIC	1,486,017	1,445,882	2,931,899	-144,117	2,787,782	194.15
194.16	07966	GA MEDICAL CLINIC	154,442	89,556	243,998	-10	243,988	194.16
194.17	07967	ELITE PERFORMANCE	510,203	113,479	623,682	0	623,682	194.17
200.00		TOTAL (SUM OF LINES 118-199)	36,626,021	43,240,400	79,866,421	0	79,866,421	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/23/2016 6:02 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	-48,500	1,294,802		1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT	-3,887	259,318		1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-8,843	1,090,659		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-502,482	9,804,477		4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	2,042,542		5.01
5.02	00591	ALL OTHER ADMIN & GENERAL	-2,106,307	8,676,114		5.02
7.00	00700	OPERATION OF PLANT	0	1,496,453		7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY	0	257,924		7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	168,950		8.00
9.00	00900	HOUSEKEEPING	0	460,099		9.00
10.00	01000	DIETARY	0	372,256		10.00
11.00	01100	CAFETERIA	-86,004	440,854		11.00
13.00	01300	NURSING ADMINISTRATION	0	623,031		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	97,315		14.00
15.00	01500	PHARMACY	0	582,102		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-469	378,186		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	3,302,091		30.00
31.00	03100	INTENSIVE CARE UNIT	0	221,808		31.00
43.00	04300	NURSERY	0	350,846		43.00
44.00	04400	SKILLED NURSING FACILITY	0	76,955		44.00
46.00	04600	OTHER LONG TERM CARE	0	1,563,963		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	2,648,485		50.00
51.00	05100	RECOVERY ROOM	0	321,985		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	102,929		52.00
53.00	05300	ANESTHESIOLOGY	-2,040,570	95,509		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-756,068	2,907,397		54.00
56.00	05600	RADIOISOTOPE	0	228,485		56.00
60.00	06000	LABORATORY	-3,300	1,869,969		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	113,410		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	461,473		65.00
66.00	06600	PHYSICAL THERAPY	0	1,409,360		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	156,084		67.00
68.00	06800	SPEECH PATHOLOGY	0	36,205		68.00
69.00	06900	ELECTROCARDIOLOGY	-252,130	40,595		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	848,783		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,693,148		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,128,197		73.00
73.01	07301	CARDIAC REHAB	0	150,667		73.01
73.02	07302	WOUND CARE	0	229,966		73.02
73.03	07303	SLEEP LAB	0	204,110		73.03
73.04	03950	DIETARY EDUCATION	0	68,263		73.04
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-402,868	9,512,097		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	-99	122,832		88.01
90.00	09000	CLINIC	0	250,576		90.00
90.01	09001	GERI PSYCH CLINIC	-27,750	346,051		90.01
90.02	09002	ORTHO CLINIC	0	0		90.02
91.00	09100	EMERGENCY	-1,435,945	1,841,164		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-350	2,214,043		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	-7,675,572	63,562,528		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.01	19201	GAH - MSO	0	349,391		192.01
192.02	19202	GAH FOUNDATION	0	220,067		192.02
194.00	07950	FALCON POINT RENTAL	0	7,301		194.00
194.01	07951	PHYSICIAN OFFICE	-6,000	733,494		194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	-3,800	851,874		194.02
194.03	07953	WELLNESS CENTER	0	175,925		194.03
194.04	07954	PSYCH CLINIC	0	459,839		194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	-3,700	323,427		194.05
194.06	07956	LASER CLINIC	0	7,024		194.06
194.07	07957	PAIN CLINIC	-3,000	49,344		194.07
194.08	07958	340B PHARMACY	0	371,901		194.08
194.09	07959	GAH CARDIOLOGY	-1,500	867,168		194.09
194.10	07960	WIC	0	238,179		194.10
194.11	07961	PULMONARY CLINIC	0	632		194.11

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0	166,142		194.12
194.13	07963	PODIATRY	-2,050	101,414		194.13
194.14	07964	9TH STREET CLINIC	0	29,697		194.14
194.15	07965	ORTHO CLINIC	-17,800	2,769,982		194.15
194.16	07966	GA MEDICAL CLINIC	0	243,988		194.16
194.17	07967	ELITE PERFORMANCE	0	623,682		194.17
200.00		TOTAL (SUM OF LINES 118-199)	-7,713,422	72,152,999		200.00

RECLASSIFICATIONS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/23/2016 6:02 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - INTEREST RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	275,464	1.00
2.00	CAP REL COSTS-BLDG & FIIX-OB UNIT	1.01	0	118,544	2.00
3.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	63,877	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	144	4.00
5.00	RURAL HEALTH CLINIC	88.00	0	144,796	5.00
6.00	RURAL HEALTH CLINIC (RHC)	88.01	0	3,034	6.00
7.00	AMBULANCE SERVICES	95.00	0	10,689	7.00
8.00	GA MEDICAL CLINIC	194.16	0	6,043	8.00
9.00	MAHOMET SPECIALTY CLINIC	194.05	0	7,117	9.00
	TOTALS		0	629,708	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	280,607	246,251	1.00
	TOTALS		280,607	246,251	
	C - OBSTETRICS				
1.00	NURSERY	43.00	309,983	40,863	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	90,941	11,988	2.00
	TOTALS		400,924	52,851	
	D - INTERNAL ALLOC BENEFITS				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	816,620	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	TOTALS		0	816,620	
	E - ADM LONG TERM CARE FEES				
1.00	ALL OTHER ADMIN & GENERAL	5.02	0	94,995	1.00
	TOTALS		0	94,995	
	F - SNF DIRECT CARE COST				
1.00	SKILLED NURSING FACILITY	44.00	69,688	7,267	1.00
	TOTALS		69,688	7,267	
	G - BOND AMORT COST				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2,045	1.00
	TOTALS		0	2,045	
	H - MME, OB, & OFFSITE BLDG DEPR				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	988,587	1.00
2.00	CAP REL COSTS-BLDG & FIIX-OB UNIT	1.01	0	144,661	2.00
3.00		0.00	0	0	3.00
4.00	ALL OTHER ADMIN & GENERAL	5.02	0	99,543	4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,623	5.00
6.00	PHYSICAL THERAPY	66.00	0	57,033	6.00
7.00	RURAL HEALTH CLINIC	88.00	0	214,534	7.00
8.00	RURAL HEALTH CLINIC (RHC)	88.01	0	635	8.00
9.00	AMBULANCE SERVICES	95.00	0	73,907	9.00
10.00	FALCON POINT RENTAL	194.00	0	7,301	10.00
11.00	PLASTIC SURG & DR. CHUNG	194.02	0	7,844	11.00
12.00	WELLNESS CENTER	194.03	0	16,617	12.00
13.00	MAHOMET SPECIALTY CLINIC	194.05	0	26,206	13.00
14.00	FAMILY HEALTHCARE OF POTOMAC	194.12	0	11,794	14.00
15.00	ORTHO CLINIC	194.15	0	11,457	15.00
16.00	GA MEDICAL CLINIC	194.16	0	1,265	16.00
	TOTALS		0	1,663,007	
	I - CAPITAL INSURANCE EXP				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	136,486	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	44,993	2.00
	TOTALS		0	181,479	
	J - NUCLEAR MED & EKG TECH SALARY				
1.00	RADIOISOTOPE	56.00	108,787	0	1.00
2.00	ELECTROCARDIOLOGY	69.00	31,102	0	2.00
	TOTALS		139,889	0	
	K - AMBULANCE BILLING & UTILITIES COST				
1.00	AMBULANCE SERVICES	95.00	0	77,417	1.00
2.00	OPERATION OF PLANT-OUTSIDE PROPERTY	7.01	0	5,843	2.00
	TOTALS		0	83,260	

RECLASSIFICATIONS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/23/2016 6:02 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	L - PHYSICIAN COSTS					
1.00	NURSING ADMINISTRATION	13.00	0	29,475		1.00
	TOTALS		0	29,475		
	M - DIETARY EDUCATION					
1.00	DIETARY EDUCATION	73.04	0	68,263		1.00
	TOTALS		0	68,263		
	O - RHC PHYSICIAN BENEFITS					
1.00	ALL OTHER ADMIN & GENERAL	5.02	0	13,741		1.00
2.00	NURSING ADMINISTRATION	13.00	0	20,462		2.00
3.00	ANESTHESIOLOGY	53.00	0	15,762		3.00
4.00	WOUND CARE	73.02	0	8,814		4.00
5.00	RURAL HEALTH CLINIC	88.00	0	501,549		5.00
6.00	RURAL HEALTH CLINIC (RHC)	88.01	0	3,582		6.00
7.00	GA MEDICAL CLINIC	194.16	0	8,091		7.00
	TOTALS		0	572,001		
	P - OFFSITE UTILITIES					
1.00	OPERATION OF PLANT-OUTSIDE PROPERTY	7.01	0	152,392		1.00
6.00						6.00
	TOTALS		0	152,392		
	Q - ICU FLOAT TO A&P					
1.00	ADULTS & PEDIATRICS	30.00	424,694	2,453		1.00
	TOTALS		424,694	2,453		
500.00	Grand Total: Increases		1,315,802	4,602,067		500.00

RECLASSIFICATIONS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/23/2016 6:02 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST RECLASS						
1.00	ALL OTHER ADMIN & GENERAL	5.02	0	629,708	11		1.00
2.00		0.00	0	0	11		2.00
3.00		0.00	0	0	11		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
	TOTALS		0	629,708			
	B - CAFETERIA						
1.00	DIETARY	10.00	280,607	246,251	0		1.00
	TOTALS		280,607	246,251			
	C - OBSTETRICS						
1.00	ADULTS & PEDIATRICS	30.00	400,924	52,851	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		400,924	52,851			
	D - INTERNAL ALLOC BENEFITS						
1.00	RURAL HEALTH CLINIC	88.00	0	460,956	0		1.00
2.00	RURAL HEALTH CLINIC (RHC)	88.01	0	6,821	0		2.00
3.00	PHYSICIAN OFFICE	194.01	0	42,842	0		3.00
4.00	PLASTIC SURG & DR. CHUNG	194.02	0	33,628	0		4.00
5.00	PSYCH CLINIC	194.04	0	7,988	0		5.00
6.00	MAHOMET SPECIALTY CLINIC	194.05	0	4,458	0		6.00
7.00	GAH CARDIOLOGY	194.09	0	68,354	0		7.00
8.00	FAMILY HEALTHCARE OF POTOMAC	194.12	0	12,089	0		8.00
9.00	PODIATRY	194.13	0	7,160	0		9.00
10.00	9TH STREET CLINIC	194.14	0	1,341	0		10.00
11.00	ORTHO CLINIC	194.15	0	155,574	0		11.00
12.00	GA MEDICAL CLINIC	194.16	0	15,409	0		12.00
	TOTALS		0	816,620			
	E - ADM LONG TERM CARE FEES						
1.00	OTHER LONG TERM CARE	46.00	0	94,995	0		1.00
	TOTALS		0	94,995			
	F - SNF DIRECT CARE COST						
1.00	OTHER LONG TERM CARE	46.00	69,688	7,267	0		1.00
	TOTALS		69,688	7,267			
	G - BOND AMORT COST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,045	14		1.00
	TOTALS		0	2,045			
	H - MME, OB, & OFFSITE BLDG DEPR						
1.00	RURAL HEALTH CLINIC	88.00	0	540	9		1.00
2.00	ALL OTHER ADMIN & GENERAL	5.02	0	3,964	9		2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	984,082	11		3.00
4.00	CAP REL COSTS-BLDG & FIXT	1.00	0	529,760	11		4.00
5.00	CAP REL COSTS-BLDG & FIXT	1.00	0	144,661	9		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
	TOTALS		0	1,663,007			
	I - CAPITAL INSURANCE EXP						
1.00	ALL OTHER ADMIN & GENERAL	5.02	0	181,479	12		1.00
2.00		0.00	0	0	12		2.00
	TOTALS		0	181,479			
	J - NUCLEAR MED & EKG TECH SALARY						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	108,787	0	0		1.00
2.00	RESPIRATORY THERAPY	65.00	31,102	0	0		2.00
	TOTALS		139,889	0			
	K - AMBULANCE BILLING & UTILITIES COST						
1.00	CASHIERING/ACCOUNTS RECEIVABLE	5.01	0	77,417	0		1.00
2.00	AMBULANCE SERVICES	95.00	0	5,843	0		2.00
	TOTALS		0	83,260			

RECLASSIFICATIONS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-6 | Date/Time Prepared: 2/23/2016 6:02 pm

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	L - PHYSICIAN COSTS					
1.00	ALL OTHER ADMIN & GENERAL	5.02	0	29,475	0	1.00
	TOTALS		0	29,475		
	M - DIETARY EDUCATION					
1.00	NURSING ADMINISTRATION	13.00	0	68,263	0	1.00
	TOTALS		0	68,263		
	O - RHC PHYSICIAN BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	572,001	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
	TOTALS		0	572,001		
	P - OFFSITE UTILITIES					
1.00	OPERATION OF PLANT	7.00	0	152,392	0	1.00
6.00	OPERATION OF PLANT				0	6.00
	TOTALS		0	152,392		
	Q - ICU FLOAT TO A&P					
1.00	INTENSIVE CARE UNIT	31.00	424,694	2,453	0	1.00
	TOTALS		424,694	2,453		
500.00	Grand Total: Decreases		1,315,802	4,602,067		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 2/23/2016 6:02 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	544,832	57,050	0	57,050	0	1.00
2.00	Land Improvements	1,345,341	292,780	0	292,780	0	2.00
3.00	Buildings and Fixtures	26,250,155	10,118,971	0	10,118,971	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	18,932,751	1,016,098	0	1,016,098	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	47,073,079	11,484,899	0	11,484,899	0	8.00
9.00	Reconciling Items	-7,375,058	0	0	0	-4,810,596	9.00
10.00	Total (line 8 minus line 9)	54,448,137	11,484,899	0	11,484,899	4,810,596	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	601,882	0	1.00
2.00	Land Improvements	1,638,121	0	2.00
3.00	Buildings and Fixtures	36,369,126	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	19,948,849	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	58,557,978	0	8.00
9.00	Reconciling Items	-2,564,462	0	9.00
10.00	Total (line 8 minus line 9)	61,122,440	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 2/23/2016 6:02 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	2,591,900	0	0	0	0	1.00
1.01	CAP REL COSTS-BLDG & FIIX-OB UNIT	0	0	0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,591,900	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	2,591,900		1.00
1.01	CAP REL COSTS-BLDG & FIIX-OB UNIT	0	0		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	2,591,900		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 2/23/2016 6:02 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	38,609,129	0	38,609,129	0.659332	0	1.00
1.01	CAP REL COSTS-BLDG & FIIX-OB UNIT	0	0	0	0.000000	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	19,948,849	0	19,948,849	0.340668	0	2.00
3.00	Total (sum of lines 1-2)	58,557,978	0	58,557,978	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,407,771	0	1.00
1.01	CAP REL COSTS-BLDG & FIIX-OB UNIT	0	0	0	144,661	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	981,838	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,534,270	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	-1,247,410	136,486	0	-2,045	1,294,802	1.00
1.01	CAP REL COSTS-BLDG & FIIX-OB UNIT	114,657	0	0	0	259,318	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	61,783	44,993	0	2,045	1,090,659	2.00
3.00	Total (sum of lines 1-2)	-1,070,970	181,479	0	0	2,644,779	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/23/2016 6:02 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIIX-OB UNIT (chapter 2)		0	CAP REL COSTS-BLDG & FIIX-OB UNIT	1.01	0	1.01
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)		0		0.00	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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,277,051			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	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		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - CAP REL COSTS-BLDG & FIIX-OB UNIT		0	CAP REL COSTS-BLDG & FIIX-OB UNIT	1.01	0	26.01
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/23/2016 6:02 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-6,749	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	A&G MISC REV	B	-44,495	ALL OTHER ADMIN & GENERAL	5.02	0	33.00
33.01	DR BARK DIRECTOR FEES	B	-12,300	RURAL HEALTH CLINIC	88.00	0	33.01
33.02	PAXTON HEALTHCARE OTHER REV	B	-11,000	RURAL HEALTH CLINIC	88.00	0	33.02
33.03	SCHOOL NURSING INCOME	B	-105,010	ALL OTHER ADMIN & GENERAL	5.02	0	33.03
33.04	HOSPICE MISC REV	B	-17,190	ALL OTHER ADMIN & GENERAL	5.02	0	33.04
33.05	LIFELINE INCOME	B	-7,091	ALL OTHER ADMIN & GENERAL	5.02	0	33.05
33.06	CAFE MISC REV	B	-86,004	CAFETERIA	11.00	0	33.06
33.07	MED RECORDS MISC REV	B	-469	MEDICAL RECORDS & LIBRARY	16.00	0	33.07
33.08	RENTAL INC - OPC	B	-39,468	CAP REL COSTS-BLDG & FIXT	1.00	9	33.08
33.09	INVEST INCOME - B&F	B	-9,032	CAP REL COSTS-BLDG & FIXT	1.00	11	33.09
33.10	INVEST INCOME - OB B&F	B	-3,887	CAP REL COSTS-BLDG & FIIX-OB UNIT	1.01	11	33.10
33.11	INVEST INCOME - MME	B	-2,094	CAP REL COSTS-MVBLE EQUIP	2.00	11	33.11
33.12	INVEST INCOME - A&G	B	-6,520	ALL OTHER ADMIN & GENERAL	5.02	0	33.12
33.13	INVEST INCOME - RAD	B	-5	RADIOLOGY-DIAGNOSTIC	54.00	0	33.13
33.14	INVEST INCOME - PAXTON	B	-2,726	RURAL HEALTH CLINIC	88.00	0	33.14
33.15	INVEST INCOME - ONARGA	B	-303	RURAL HEALTH CLINIC	88.00	0	33.15
33.16	INVEST INCOME - FORREST	B	-1,248	RURAL HEALTH CLINIC	88.00	0	33.16
33.17	INVEST INCOME - FARMER CITY	B	-471	RURAL HEALTH CLINIC	88.00	0	33.17
33.18	INVEST INCOME - RHC II	B	-99	RURAL HEALTH CLINIC (RHC)	88.01	0	33.18
33.19	INVEST INCOME - AMBULANCE	B	-350	AMBULANCE SERVICES	95.00	0	33.19
33.20	INTERNALLY ALLOCATED RENT EXP - RHC	A	-183,158	RURAL HEALTH CLINIC	88.00	0	33.20
33.21	INTERNALLY ALLOCATED RENT EXP - ORTH	A	-17,800	ORTHO CLINIC	194.15	0	33.21
33.22	INTERNALLY ALLOCATED RENT EXP - PO	A	-6,000	PHYSICIAN OFFICE	194.01	0	33.22
33.23	INTERNALLY ALLOCATED RENT EXP - PC	A	-3,800	PLASTIC SURG & DR. CHUNG	194.02	0	33.23
33.24	INTERNALLY ALLOCATED RENT EXP - CLIN	A	-3,000	PAIN CLINIC	194.07	0	33.24
33.25	INTERNALLY ALLOCATED RENT EXP - MAHO	A	-3,700	MAHOMET SPECIALTY CLINIC	194.05	0	33.25
33.26	INTERNALLY ALLOCATED RENT EXP - CARD	A	-1,500	GAH CARDIOLOGY	194.09	0	33.26
34.00	INTERNALLY ALLOCATED RENT EXP - PODI	A	-2,050	PODIATRY	194.13	0	34.00
35.00	HOUSE RENT	A	-187	ANESTHESIOLOGY	53.00	0	35.00
36.00	LOBBYING DUES	A	-20,385	ALL OTHER ADMIN & GENERAL	5.02	0	36.00
37.00	STATE PROVIDER TAX EXP	A	-240,517	ALL OTHER ADMIN & GENERAL	5.02	0	37.00
38.01	OP STATE PROVIDER TAX EXP	A	-346,085	ALL OTHER ADMIN & GENERAL	5.02	0	38.01
40.00	CRNA SALARIES	A	-1,238,520	ANESTHESIOLOGY	53.00	0	40.00
41.00	CRNA BENEFITS	A	-235,908	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	41.00
42.00	PHYSICIAN RECRUITMENT	A	-2,432	ALL OTHER ADMIN & GENERAL	5.02	0	42.00
43.00	PUBLIC RELATIONS OFFSET	A	-577,817	ALL OTHER ADMIN & GENERAL	5.02	0	43.00
44.00	GIBSON PHO EXP	A	-524,979	ALL OTHER ADMIN & GENERAL	5.02	0	44.00
45.00	RHC LAB SRVCS COST	A	-35,707	RURAL HEALTH CLINIC	88.00	0	45.00
45.01	MISC DONATIONS (COMM ED)	A	-213,786	ALL OTHER ADMIN & GENERAL	5.02	0	45.01
45.02	PT B PHYSICIAN BENEFITS	A	-266,574	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.02
45.03	RHC DRS HOSP VISIT	A	-155,955	RURAL HEALTH CLINIC	88.00	0	45.03
45.04			0		0.00	0	45.04
45.05			0		0.00	0	45.05
45.07			0		0.00	0	45.07
45.08			0		0.00	0	45.08
45.10			0		0.00	0	45.10
45.11			0		0.00	0	45.11
45.13			0		0.00	0	45.13
45.14			0		0.00	0	45.14
45.15			0		0.00	0	45.15

ADJUSTMENTS TO EXPENSES | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8 | Date/Time Prepared: 2/23/2016 6:02 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-7,713,422				50.00

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 2/23/2016 6:02 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	44.00	SKILLED NURSING FACILITY	20,800	0	20,800	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	252,130	252,130	0	0	0	2.00
3.00	73.01	CARDIAC REHAB	10,650	0	10,650	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	679,144	679,144	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	22,651	22,651	0	0	0	5.00
6.00	91.00	EMERGENCY	1,845,628	1,435,945	409,683	0	0	6.00
7.00	60.00	LABORATORY	3,300	3,300	0	0	0	7.00
8.00	53.00	ANESTHESIOLOGY	230,121	230,121	0	0	0	8.00
9.00	73.03	SLEEP LAB	93,003	0	93,003	0	0	9.00
10.00	90.01	GERI PSYCH CLINIC	27,750	27,750	0	0	0	10.00
11.00	53.00	ANESTHESIOLOGY	571,742	571,742	0	0	0	11.00
12.00	54.00	RADIOLOGY-DIAGNOSTIC	54,268	54,268	0	0	0	12.00
200.00			3,811,187	3,277,051	534,136		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	44.00	SKILLED NURSING FACILITY	0	0	0	0	0	1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	2.00
3.00	73.01	CARDIAC REHAB	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	8.00
9.00	73.03	SLEEP LAB	0	0	0	0	0	9.00
10.00	90.01	GERI PSYCH CLINIC	0	0	0	0	0	10.00
11.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	11.00
12.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	12.00
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	44.00	SKILLED NURSING FACILITY	0	0	0	0		1.00
2.00	69.00	ELECTROCARDIOLOGY	0	0	0	252,130		2.00
3.00	73.01	CARDIAC REHAB	0	0	0	0		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	679,144		4.00
5.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	22,651		5.00
6.00	91.00	EMERGENCY	0	0	0	1,435,945		6.00
7.00	60.00	LABORATORY	0	0	0	3,300		7.00
8.00	53.00	ANESTHESIOLOGY	0	0	0	230,121		8.00
9.00	73.03	SLEEP LAB	0	0	0	0		9.00
10.00	90.01	GERI PSYCH CLINIC	0	0	0	27,750		10.00
11.00	53.00	ANESTHESIOLOGY	0	0	0	571,742		11.00
12.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	54,268		12.00
200.00			0	0	0	3,277,051		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	BLDG & FIIX-OB UNIT	MVBLE EQUIP		
			0	1.00	1.01	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,294,802	1,294,802				1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT	259,318	0	259,318			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,090,659			1,090,659		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	9,804,477	12,828	0	0	9,817,305	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,042,542	7,182	0	0	462,545	5.01
5.02	00591	ALL OTHER ADMIN & GENERAL	8,676,114	301,904	8,112	392,488	1,395,355	5.02
7.00	00700	OPERATION OF PLANT	1,496,453	139,849	0	2,363	151,436	7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY	257,924	0	0	0	24,252	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	168,950	25,958	0	8,021	43,725	8.00
9.00	00900	HOUSEKEEPING	460,099	7,103	2,133	0	131,783	9.00
10.00	01000	DIETARY	372,256	28,256	0	3,198	70,956	10.00
11.00	01100	CAFETERIA	440,854	13,865	0	0	100,425	11.00
13.00	01300	NURSING ADMINISTRATION	623,031	1,799	0	0	143,311	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	97,315	6,040	0	0	0	14.00
15.00	01500	PHARMACY	582,102	14,062	0	0	168,589	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	378,186	13,603	0	83	101,224	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,302,091	54,608	168,955	42,108	1,072,106	30.00
31.00	03100	INTENSIVE CARE UNIT	221,808	11,646	0	0	76,121	31.00
43.00	04300	NURSERY	350,846	0	16,250	0	110,938	43.00
44.00	04400	SKILLED NURSING FACILITY	76,955	8,390	0	0	24,940	44.00
46.00	04600	OTHER LONG TERM CARE	1,563,963	158,244	0	12,249	506,863	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,648,485	178,228	11,615	152,056	587,182	50.00
51.00	05100	RECOVERY ROOM	321,985	20,247	0	340	102,190	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	102,929	0	50,620	0	32,546	52.00
53.00	05300	ANESTHESIOLOGY	95,509	1,169	1,633	16,102	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,907,397	97,898	0	230,767	523,273	54.00
56.00	05600	RADIOISOTOPE	228,485	4,267	0	0	30,506	56.00
60.00	06000	LABORATORY	1,869,969	25,157	0	38,129	301,144	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	113,410	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	461,473	14,443	0	12,883	148,037	65.00
66.00	06600	PHYSICAL THERAPY	1,409,360	4,451	0	25,596	436,680	66.00
67.00	06700	OCCUPATIONAL THERAPY	156,084	0	0	0	53,219	67.00
68.00	06800	SPEECH PATHOLOGY	36,205	0	0	0	118	68.00
69.00	06900	ELECTROCARDIOLOGY	40,595	0	0	0	11,131	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	848,783	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,693,148	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,128,197	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	150,667	10,780	0	6,233	48,251	73.01
73.02	07302	WOUND CARE	229,966	15,113	0	0	42,258	73.02
73.03	07303	SLEEP LAB	204,110	9,414	0	3,053	37,237	73.03
73.04	03950	DIETARY EDUCATION	68,263	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,512,097	1,917	0	32,563	835,076	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	122,832	0	0	750	14,592	88.01
90.00	09000	CLINIC	250,576	30,029	0	471	76,874	90.00
90.01	09001	GERI PSYCH CLINIC	346,051	0	0	0	63,293	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	1,841,164	69,721	0	32,075	459,620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,214,043	0	0	50,698	648,564	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,562,528	1,288,171	259,318	1,062,226	9,036,360	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,729	0	0	0	190.00
192.01	19201	GAH - MSO	349,391	0	0	0	58,693	192.01
192.02	19202	GAH FOUNDATION	220,067	2,902	0	0	14,545	192.02
194.00	07950	FALCON POINT RENTAL	7,301	0	0	0	0	194.00
194.01	07951	PHYSICIAN OFFICE	733,494	0	0	22,987	51,751	194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	851,874	0	0	0	9,717	194.02
194.03	07953	WELLNESS CENTER	175,925	0	0	0	47,758	194.03
194.04	07954	PSYCH CLINIC	459,839	0	0	0	62,759	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	323,427	0	0	0	36,520	194.05
194.06	07956	LASER CLINIC	7,024	0	0	0	0	194.06
194.07	07957	PAIN CLINIC	49,344	0	0	0	1,754	194.07

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIIX-OB UNIT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	1.01	2.00	4.00	
194.08	07958	340B PHARMACY	371,901	0	0	0	0	194.08
194.09	07959	GAH CARDIOLOGY	867,168	0	0	3,753	37,623	194.09
194.10	07960	WIC	238,179	0	0	0	78,820	194.10
194.11	07961	PULMONARY CLINIC	632	0	0	0	0	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	166,142	0	0	0	43,542	194.12
194.13	07963	PODIATRY	101,414	0	0	0	1,008	194.13
194.14	07964	9TH STREET CLINIC	29,697	0	0	0	5,900	194.14
194.15	07965	ORTHO CLINIC	2,769,982	0	0	0	118,897	194.15
194.16	07966	GA MEDICAL CLINIC	243,988	0	0	1,693	29,064	194.16
194.17	07967	ELITE PERFORMANCE	623,682	0	0	0	182,594	194.17
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	72,152,999	1,294,802	259,318	1,090,659	9,817,305	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	Subtotal	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	ALL OTHER ADMIN & GENERAL	OPERATION OF PLANT	
			4A	5.01	5A.01	5.02	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	2,512,269	2,512,269				5.01
5.02	00591	ALL OTHER ADMIN & GENERAL	10,773,973	0	10,773,973	10,773,973		5.02
7.00	00700	OPERATION OF PLANT	1,790,101	0	1,790,101	314,220	2,104,321	7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY	282,176	0	282,176	49,531	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	246,654	0	246,654	43,296	57,003	8.00
9.00	00900	HOUSEKEEPING	601,118	0	601,118	105,515	17,934	9.00
10.00	01000	DIETARY	474,666	0	474,666	83,319	62,049	10.00
11.00	01100	CAFETERIA	555,144	0	555,144	97,446	30,448	11.00
13.00	01300	NURSING ADMINISTRATION	768,141	0	768,141	134,833	3,950	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	103,355	0	103,355	18,142	13,263	14.00
15.00	01500	PHARMACY	764,753	0	764,753	134,239	30,880	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	493,096	0	493,096	86,554	29,871	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,639,868	347,974	4,987,842	875,526	304,880	30.00
31.00	03100	INTENSIVE CARE UNIT	309,575	23,217	332,792	58,416	25,575	31.00
43.00	04300	NURSERY	478,034	35,851	513,885	90,203	17,790	43.00
44.00	04400	SKILLED NURSING FACILITY	110,285	0	110,285	19,359	18,424	44.00
46.00	04600	OTHER LONG TERM CARE	2,241,319	0	2,241,319	393,423	347,496	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,577,566	268,307	3,845,873	675,074	404,095	50.00
51.00	05100	RECOVERY ROOM	444,762	33,356	478,118	83,925	44,461	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,095	13,957	200,052	35,116	55,417	52.00
53.00	05300	ANESTHESIOLOGY	114,413	8,581	122,994	21,589	4,354	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,759,335	281,939	4,041,274	709,373	214,979	54.00
56.00	05600	RADIOISOTOPE	263,258	19,744	283,002	49,676	9,371	56.00
60.00	06000	LABORATORY	2,234,399	167,573	2,401,972	421,623	55,244	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	113,410	8,505	121,915	21,400	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	636,836	47,761	684,597	120,169	31,716	65.00
66.00	06600	PHYSICAL THERAPY	1,876,087	140,701	2,016,788	354,011	9,774	66.00
67.00	06700	OCCUPATIONAL THERAPY	209,303	15,697	225,000	39,495	0	67.00
68.00	06800	SPEECH PATHOLOGY	36,323	2,724	39,047	6,854	0	68.00
69.00	06900	ELECTROCARDIOLOGY	51,726	3,879	55,605	9,760	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	848,783	63,656	912,439	160,162	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,693,148	201,978	2,895,126	508,187	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,128,197	84,611	1,212,808	212,887	0	73.00
73.01	07301	CARDIAC REHAB	215,931	16,194	232,125	40,745	23,672	73.01
73.02	07302	WOUND CARE	287,337	21,549	308,886	54,219	33,187	73.02
73.03	07303	SLEEP LAB	253,814	19,035	272,849	47,894	20,673	73.03
73.04	03950	DIETARY EDUCATION	68,263	5,120	73,383	12,881	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,381,653	0	10,381,653	1,822,300	4,210	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	138,174	0	138,174	24,254	0	88.01
90.00	09000	CLINIC	357,950	26,845	384,795	67,544	65,941	90.00
90.01	09001	GERI PSYCH CLINIC	409,344	30,700	440,044	77,242	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	2,402,580	180,186	2,582,766	453,358	153,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0			92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,913,305	0	2,913,305	511,378	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	62,746,519	2,069,640	62,303,890	9,045,138	2,089,760	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,729	0	3,729	655	8,189	190.00
192.01	19201	GAH - MSO	408,084	0	408,084	71,632	0	192.01
192.02	19202	GAH FOUNDATION	237,514	0	237,514	41,691	6,372	192.02
194.00	07950	FALCON POINT RENTAL	7,301	548	7,849	1,378	0	194.00
194.01	07951	PHYSICIAN OFFICE	808,232	60,615	868,847	152,510	0	194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	861,591	0	861,591	151,237	0	194.02
194.03	07953	WELLNESS CENTER	223,683	0	223,683	39,264	0	194.03
194.04	07954	PSYCH CLINIC	522,598	39,193	561,791	98,612	0	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	359,947	26,995	386,942	67,921	0	194.05
194.06	07956	LASER CLINIC	7,024	527	7,551	1,325	0	194.06
194.07	07957	PAIN CLINIC	51,098	3,832	54,930	9,642	0	194.07
194.08	07958	340B PHARMACY	371,901	0	371,901	65,281	0	194.08
194.09	07959	GAH CARDIOLOGY	908,544	68,138	976,682	171,439	0	194.09
194.10	07960	WIC	316,999	0	316,999	55,643	0	194.10
194.11	07961	PULMONARY CLINIC	632	47	679	119	0	194.11

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	Subtotal	CASHIERING/ACCOUNTS RECEIVABLE	Subtotal	ALL OTHER ADMIN & GENERAL	OPERATION OF PLANT	
			4A	5.01	5A.01	5.02	7.00	
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	209,684	15,726	225,410	39,567	0	194.12
194.13	07963	PODIATRY	102,422	7,681	110,103	19,327	0	194.13
194.14	07964	9TH STREET CLINIC	35,597	2,670	38,267	6,717	0	194.14
194.15	07965	ORTHO CLINIC	2,888,879	216,657	3,105,536	545,121	0	194.15
194.16	07966	GA MEDICAL CLINIC	274,745	0	274,745	48,227	0	194.16
194.17	07967	ELITE PERFORMANCE	806,276	0	806,276	141,527	0	194.17
200.00		Cross Foot Adjustments	0		0			200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	72,152,999	2,512,269	72,152,999	10,773,973	2,104,321	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	OPERATION OF PLANT-OUTSIDE PROPERTY	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00591	ALL OTHER ADMIN & GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY	331,707					7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	346,953				8.00
9.00	00900	HOUSEKEEPING	42	37,100	761,709			9.00
10.00	01000	DIETARY	0	5,328	12,711	638,073		10.00
11.00	01100	CAFETERIA	0	8,882	6,237	0	698,157	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	809	0	12,788	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	2,717	0	0	14.00
15.00	01500	PHARMACY	0	0	6,326	0	5,131	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	6,119	0	17,970	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	62,574	62,454	131,434	111,661	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	5,239	1,242	29,469	31.00
43.00	04300	NURSERY	0	1,871	3,644	0	11,834	43.00
44.00	04400	SKILLED NURSING FACILITY	0	19,273	3,774	23,702	4,048	44.00
46.00	04600	OTHER LONG TERM CARE	0	103,947	71,184	481,695	82,194	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	36,099	82,779	0	77,605	50.00
51.00	05100	RECOVERY ROOM	0	0	9,108	0	20,497	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	14,184	11,352	0	3,481	52.00
53.00	05300	ANESTHESIOLOGY	5,086	0	10,283	0	13,484	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	11,927	44,038	0	70,179	54.00
56.00	05600	RADIOISOTOPE	0	0	1,920	0	11,989	56.00
60.00	06000	LABORATORY	0	0	11,317	0	55,432	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	6,497	0	18,409	65.00
66.00	06600	PHYSICAL THERAPY	28,039	18,590	53,772	0	85,030	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	4,795	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	1,676	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0	0	4,849	0	6,600	73.01
73.02	07302	WOUND CARE	0	0	6,798	0	5,105	73.02
73.03	07303	SLEEP LAB	0	0	4,235	0	4,847	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	130,567	0	66,093	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	6,158	0	11,370	0	0	88.01
90.00	09000	CLINIC	0	0	13,508	0	11,654	90.00
90.01	09001	GERI PSYCH CLINIC	12,898	0	23,815	0	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	27,178	31,363	0	32,279	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	27,428	0	32,922	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	210,218	346,953	607,233	638,073	698,157	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1,677	0	0	190.00
192.01	19201	GAH - MSO	0	0	0	0	0	192.01
192.02	19202	GAH FOUNDATION	0	0	1,305	0	0	192.02
194.00	07950	FALCON POINT RENTAL	6,168	0	0	0	0	194.00
194.01	07951	PHYSICIAN OFFICE	6,449	0	11,907	0	0	194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	4,971	0	9,179	0	0	194.02
194.03	07953	WELLNESS CENTER	22,393	0	0	0	0	194.03
194.04	07954	PSYCH CLINIC	0	0	0	0	0	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	6,814	0	12,581	0	0	194.05
194.06	07956	LASER CLINIC	0	0	0	0	0	194.06
194.07	07957	PAIN CLINIC	0	0	0	0	0	194.07
194.08	07958	340B PHARMACY	0	0	0	0	0	194.08
194.09	07959	GAH CARDIOLOGY	0	0	0	0	0	194.09
194.10	07960	WIC	0	0	0	0	0	194.10
194.11	07961	PULMONARY CLINIC	0	0	0	0	0	194.11

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	OPERATION OF PLANT-OUTSIDE PROPERTY	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.01	8.00	9.00	10.00	11.00	
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	15,010	0	16,491	0	0	194.12
194.13	07963	PODIATRY	0	0	0	0	0	194.13
194.14	07964	9TH STREET CLINIC	0	0	0	0	0	194.14
194.15	07965	ORTHO CLINIC	7,300	0	13,478	0	0	194.15
194.16	07966	GA MEDICAL CLINIC	12,268	0	22,651	0	0	194.16
194.17	07967	ELITE PERFORMANCE	40,116	0	65,207	0	0	194.17
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	331,707	346,953	761,709	638,073	698,157	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00591	ALL OTHER ADMIN & GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	920,521					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	137,477				14.00
15.00	01500	PHARMACY	0	120	941,449			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	63	0	633,673		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	244,892	3,791	1,963	132,821	6,919,838	30.00
31.00	03100	INTENSIVE CARE UNIT	64,625	0	0	1,072	518,430	31.00
43.00	04300	NURSERY	25,978	0	0	5,339	670,544	43.00
44.00	04400	SKILLED NURSING FACILITY	8,871	0	0	11,344	219,080	44.00
46.00	04600	OTHER LONG TERM CARE	180,275	964	100	0	3,902,597	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	170,234	12,891	9,450	83,749	5,397,849	50.00
51.00	05100	RECOVERY ROOM	44,979	423	0	0	681,511	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,621	0	0	0	327,223	52.00
53.00	05300	ANESTHESIOLOGY	0	938	7,230	0	185,958	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	347	3,416	146,410	5,241,943	54.00
56.00	05600	RADIOISOTOPE	0	33	79	0	356,070	56.00
60.00	06000	LABORATORY	0	1,545	37	48,619	2,995,789	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	143,315	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	40,395	50	100	5,505	907,438	65.00
66.00	06600	PHYSICAL THERAPY	0	178	698	7,174	2,574,054	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7	0	0	269,297	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	45,901	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1	0	0	67,042	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	28,311	0	0	1,100,912	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	82,040	0	0	3,485,353	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	737,298	0	2,162,993	73.00
73.01	07301	CARDIAC REHAB	14,502	23	0	1,859	324,375	73.01
73.02	07302	WOUND CARE	11,182	78	52	10,582	430,089	73.02
73.03	07303	SLEEP LAB	10,647	13	0	5,482	366,640	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	86,264	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,563	72,897	0	12,480,283	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	19	3,690	0	183,665	88.01
90.00	09000	CLINIC	25,537	264	31	1,978	571,252	90.00
90.01	09001	GERI PSYCH CLINIC	0	24	40	4,814	558,877	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	70,783	2,032	941	161,300	3,515,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	312	6,770	0	3,492,115	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	920,521	137,030	844,792	628,048	60,181,800	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	14,250	190.00
192.01	19201	GAH - MSO	0	24	0	0	479,740	192.01
192.02	19202	GAH FOUNDATION	0	1	0	0	286,883	192.02
194.00	07950	FALCON POINT RENTAL	0	0	0	0	15,395	194.00
194.01	07951	PHYSICIAN OFFICE	0	48	54	0	1,039,815	194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	0	38	3,517	0	1,030,533	194.02
194.03	07953	WELLNESS CENTER	0	60	0	0	285,400	194.03
194.04	07954	PSYCH CLINIC	0	1	0	0	660,404	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	0	45	2,862	0	477,165	194.05
194.06	07956	LASER CLINIC	0	0	0	0	8,876	194.06
194.07	07957	PAIN CLINIC	0	0	0	0	64,572	194.07
194.08	07958	340B PHARMACY	0	0	0	0	437,182	194.08
194.09	07959	GAH CARDIOLOGY	0	32	422	0	1,148,575	194.09
194.10	07960	WIC	0	9	0	0	372,651	194.10
194.11	07961	PULMONARY CLINIC	0	0	0	0	798	194.11

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	
			13.00	14.00	15.00	16.00	24.00	
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0	11	1,682	0	298,171	194.12
194.13	07963	PODIATRY	0	0	0	0	129,430	194.13
194.14	07964	9TH STREET CLINIC	0	50	327	0	45,361	194.14
194.15	07965	ORTHO CLINIC	0	86	79,459	5,625	3,756,605	194.15
194.16	07966	GA MEDICAL CLINIC	0	42	8,334	0	366,267	194.16
194.17	07967	ELITE PERFORMANCE	0	0	0	0	1,053,126	194.17
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	920,521	137,477	941,449	633,673	72,152,999	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE				5.01
5.02	00591	ALL OTHER ADMIN & GENERAL				5.02
7.00	00700	OPERATION OF PLANT				7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY				7.01
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-45,108	6,874,730		30.00
31.00	03100	INTENSIVE CARE UNIT	0	518,430		31.00
43.00	04300	NURSERY	0	670,544		43.00
44.00	04400	SKILLED NURSING FACILITY	0	219,080		44.00
46.00	04600	OTHER LONG TERM CARE	0	3,902,597		46.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	5,397,849		50.00
51.00	05100	RECOVERY ROOM	0	681,511		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	327,223		52.00
53.00	05300	ANESTHESIOLOGY	0	185,958		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,241,943		54.00
56.00	05600	RADIOISOTOPE	0	356,070		56.00
60.00	06000	LABORATORY	0	2,995,789		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	143,315		63.00
64.00	06400	INTRAVENOUS THERAPY	45,108	45,108		64.00
65.00	06500	RESPIRATORY THERAPY	0	907,438		65.00
66.00	06600	PHYSICAL THERAPY	0	2,574,054		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	269,297		67.00
68.00	06800	SPEECH PATHOLOGY	0	45,901		68.00
69.00	06900	ELECTROCARDIOLOGY	0	67,042		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,100,912		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,485,353		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,162,993		73.00
73.01	07301	CARDIAC REHAB	0	324,375		73.01
73.02	07302	WOUND CARE	0	430,089		73.02
73.03	07303	SLEEP LAB	0	366,640		73.03
73.04	03950	DIETARY EDUCATION	0	86,264		73.04
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	12,480,283		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	183,665		88.01
90.00	09000	CLINIC	0	571,252		90.00
90.01	09001	GERI PSYCH CLINIC	0	558,877		90.01
90.02	09002	ORTHO CLINIC	0	0		90.02
91.00	09100	EMERGENCY	0	3,515,103		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	3,492,115		95.00
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	60,181,800		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,250		190.00
192.01	19201	GAH - MSO	0	479,740		192.01
192.02	19202	GAH FOUNDATION	0	286,883		192.02
194.00	07950	FALCON POINT RENTAL	0	15,395		194.00
194.01	07951	PHYSICIAN OFFICE	0	1,039,815		194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	0	1,030,533		194.02
194.03	07953	WELLNESS CENTER	0	285,400		194.03
194.04	07954	PSYCH CLINIC	0	660,404		194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	0	477,165		194.05
194.06	07956	LASER CLINIC	0	8,876		194.06
194.07	07957	PAIN CLINIC	0	64,572		194.07
194.08	07958	340B PHARMACY	0	437,182		194.08
194.09	07959	GAH CARDIOLOGY	0	1,148,575		194.09

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part I Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			25.00	26.00		
194.10	07960	WIC	0	372,651		194.10
194.11	07961	PULMONARY CLINIC	0	798		194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0	298,171		194.12
194.13	07963	PODIATRY	0	129,430		194.13
194.14	07964	9TH STREET CLINIC	0	45,361		194.14
194.15	07965	ORTHO CLINIC	0	3,756,605		194.15
194.16	07966	GA MEDICAL CLINIC	0	366,267		194.16
194.17	07967	ELITE PERFORMANCE	0	1,053,126		194.17
200.00		Cross Foot Adjustments	0	0		200.00
201.00		Negative Cost Centers	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	72,152,999		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS BLDG & FIIX-OB UNIT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	12,828	0	0	12,828	4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	0	7,182	0	0	7,182	5.01
5.02	00591	ALL OTHER ADMIN & GENERAL	0	301,904	8,112	392,488	702,504	5.02
7.00	00700	OPERATION OF PLANT	0	139,849	0	2,363	142,212	7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY	0	0	0	0	0	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,958	0	8,021	33,979	8.00
9.00	00900	HOUSEKEEPING	0	7,103	2,133	0	9,236	9.00
10.00	01000	DIETARY	0	28,256	0	3,198	31,454	10.00
11.00	01100	CAFETERIA	0	13,865	0	0	13,865	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,799	0	0	1,799	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	6,040	0	0	6,040	14.00
15.00	01500	PHARMACY	0	14,062	0	0	14,062	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,603	0	83	13,686	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	54,608	168,955	42,108	265,671	30.00
31.00	03100	INTENSIVE CARE UNIT	0	11,646	0	0	11,646	31.00
43.00	04300	NURSERY	0	0	16,250	0	16,250	43.00
44.00	04400	SKILLED NURSING FACILITY	0	8,390	0	0	8,390	44.00
46.00	04600	OTHER LONG TERM CARE	0	158,244	0	12,249	170,493	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	178,228	11,615	152,056	341,899	50.00
51.00	05100	RECOVERY ROOM	0	20,247	0	340	20,587	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	50,620	0	50,620	52.00
53.00	05300	ANESTHESIOLOGY	0	1,169	1,633	16,102	18,904	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	97,898	0	230,767	328,665	54.00
56.00	05600	RADIOISOTOPE	0	4,267	0	0	4,267	56.00
60.00	06000	LABORATORY	0	25,157	0	38,129	63,286	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	14,443	0	12,883	27,326	65.00
66.00	06600	PHYSICAL THERAPY	0	4,451	0	25,596	30,047	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0	10,780	0	6,233	17,013	73.01
73.02	07302	WOUND CARE	0	15,113	0	0	15,113	73.02
73.03	07303	SLEEP LAB	0	9,414	0	3,053	12,467	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,917	0	32,563	34,480	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	750	750	88.01
90.00	09000	CLINIC	0	30,029	0	471	30,500	90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0	0	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	69,721	0	32,075	101,796	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	50,698	50,698	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,288,171	259,318	1,062,226	2,609,715	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3,729	0	0	3,729	190.00
192.01	19201	GAH - MSO	0	0	0	0	0	192.01
192.02	19202	GAH FOUNDATION	0	2,902	0	0	2,902	192.02
194.00	07950	FALCON POINT RENTAL	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN OFFICE	0	0	0	22,987	22,987	194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	0	0	0	0	0	194.02
194.03	07953	WELLNESS CENTER	0	0	0	0	0	194.03
194.04	07954	PSYCH CLINIC	0	0	0	0	0	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	0	0	0	0	0	194.05
194.06	07956	LASER CLINIC	0	0	0	0	0	194.06
194.07	07957	PAIN CLINIC	0	0	0	0	0	194.07
194.08	07958	340B PHARMACY	0	0	0	0	0	194.08

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS				
				BLDG & FIXT	BLDG & FIIX-OB UNIT	MVBLE EQUIP	Subtotal	
			0	1.00	1.01	2.00	2A	
194.09	07959	GAH CARDIOLOGY	0	0	0	3,753	3,753	194.09
194.10	07960	WIC	0	0	0	0	0	194.10
194.11	07961	PULMONARY CLINIC	0	0	0	0	0	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0	0	0	0	0	194.12
194.13	07963	PODIATRY	0	0	0	0	0	194.13
194.14	07964	9TH STREET CLINIC	0	0	0	0	0	194.14
194.15	07965	ORTHO CLINIC	0	0	0	0	0	194.15
194.16	07966	GA MEDICAL CLINIC	0	0	0	1,693	1,693	194.16
194.17	07967	ELITE PERFORMANCE	0	0	0	0	0	194.17
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,294,802	259,318	1,090,659	2,644,779	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/ACCOUNTS RECEIVABLE	ALL OTHER ADMIN & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-OUTSIDE PROPERTY	
			4.00	5.01	5.02	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	12,828					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	605	7,787				5.01
5.02	00591	ALL OTHER ADMIN & GENERAL	1,813	0	704,317			5.02
7.00	00700	OPERATION OF PLANT	198	0	20,541	162,951		7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY	32	0	3,238	0	3,270	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	57	0	2,830	4,414	0	8.00
9.00	00900	HOUSEKEEPING	172	0	6,898	1,389	0	9.00
10.00	01000	DIETARY	93	0	5,447	4,805	0	10.00
11.00	01100	CAFETERIA	131	0	6,370	2,358	0	11.00
13.00	01300	NURSING ADMINISTRATION	187	0	8,814	306	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	1,186	1,027	0	14.00
15.00	01500	PHARMACY	220	0	8,776	2,391	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	132	0	5,658	2,313	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,402	1,090	57,235	23,609	0	30.00
31.00	03100	INTENSIVE CARE UNIT	100	72	3,819	1,980	0	31.00
43.00	04300	NURSERY	145	111	5,897	1,378	0	43.00
44.00	04400	SKILLED NURSING FACILITY	33	0	1,266	1,427	0	44.00
46.00	04600	OTHER LONG TERM CARE	663	0	25,719	26,909	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	768	830	44,131	31,291	0	50.00
51.00	05100	RECOVERY ROOM	134	103	5,486	3,443	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	43	43	2,296	4,291	0	52.00
53.00	05300	ANESTHESIOLOGY	0	27	1,411	337	50	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	684	872	46,374	16,647	0	54.00
56.00	05600	RADIOISOTOPE	40	61	3,247	726	0	56.00
60.00	06000	LABORATORY	394	518	27,563	4,278	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	26	1,399	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	194	148	7,856	2,456	0	65.00
66.00	06600	PHYSICAL THERAPY	571	435	23,143	757	276	66.00
67.00	06700	OCCUPATIONAL THERAPY	70	49	2,582	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	8	448	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	15	12	638	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	197	10,470	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	625	33,222	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	262	13,917	0	0	73.00
73.01	07301	CARDIAC REHAB	63	50	2,664	1,833	0	73.01
73.02	07302	WOUND CARE	55	67	3,544	2,570	0	73.02
73.03	07303	SLEEP LAB	49	59	3,131	1,601	0	73.03
73.04	03950	DIETARY EDUCATION	0	16	842	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,092	0	119,120	326	1,288	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	19	0	1,586	0	61	88.01
90.00	09000	CLINIC	101	83	4,416	5,106	0	90.00
90.01	09001	GERI PSYCH CLINIC	83	95	5,050	0	127	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	601	557	29,637	11,856	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	848	0	33,430	0	270	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,807	6,416	591,297	161,824	2,072	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	43	634	0	190.00
192.01	19201	GAH - MSO	77	0	4,683	0	0	192.01
192.02	19202	GAH FOUNDATION	19	0	2,725	493	0	192.02
194.00	07950	FALCON POINT RENTAL	0	2	90	0	61	194.00
194.01	07951	PHYSICIAN OFFICE	68	188	9,970	0	64	194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	13	0	9,887	0	49	194.02
194.03	07953	WELLNESS CENTER	62	0	2,567	0	221	194.03
194.04	07954	PSYCH CLINIC	82	121	6,447	0	0	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	48	84	4,440	0	67	194.05
194.06	07956	LASER CLINIC	0	2	87	0	0	194.06
194.07	07957	PAIN CLINIC	2	12	630	0	0	194.07
194.08	07958	340B PHARMACY	0	0	4,268	0	0	194.08
194.09	07959	GAH CARDIOLOGY	49	211	11,207	0	0	194.09
194.10	07960	WIC	103	0	3,638	0	0	194.10
194.11	07961	PULMONARY CLINIC	0	0	8	0	0	194.11

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	CASHIERING/ACCOUNTS RECEIVABLE	ALL OTHER ADMIN & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT-OUTSIDE PROPERTY	
			4.00	5.01	5.02	7.00	7.01	
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	57	49	2,587	0	148	194.12
194.13	07963	PODIATRY	1	24	1,263	0	0	194.13
194.14	07964	9TH STREET CLINIC	8	8	439	0	0	194.14
194.15	07965	ORTHO CLINIC	155	670	35,636	0	72	194.15
194.16	07966	GA MEDICAL CLINIC	38	0	3,153	0	121	194.16
194.17	07967	ELITE PERFORMANCE	239	0	9,252	0	395	194.17
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,828	7,787	704,317	162,951	3,270	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00591	ALL OTHER ADMIN & GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	41,280					8.00
9.00	00900	HOUSEKEEPING	4,414	22,109				9.00
10.00	01000	DIETARY	634	369	42,802			10.00
11.00	01100	CAFETERIA	1,057	181	0	23,962		11.00
13.00	01300	NURSING ADMINISTRATION	0	23	0	439	11,568	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	79	0	0	0	14.00
15.00	01500	PHARMACY	0	184	0	176	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	178	0	617	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,445	1,813	8,817	3,832	3,078	30.00
31.00	03100	INTENSIVE CARE UNIT	0	152	83	1,011	812	31.00
43.00	04300	NURSERY	223	106	0	406	326	43.00
44.00	04400	SKILLED NURSING FACILITY	2,293	110	1,590	139	111	44.00
46.00	04600	OTHER LONG TERM CARE	12,366	2,066	32,312	2,821	2,265	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,295	2,402	0	2,664	2,139	50.00
51.00	05100	RECOVERY ROOM	0	264	0	703	565	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,688	330	0	119	96	52.00
53.00	05300	ANESTHESIOLOGY	0	298	0	463	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,419	1,278	0	2,409	0	54.00
56.00	05600	RADIOISOTOPE	0	56	0	411	0	56.00
60.00	06000	LABORATORY	0	328	0	1,903	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	189	0	632	508	65.00
66.00	06600	PHYSICAL THERAPY	2,212	1,561	0	2,918	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	165	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	58	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0	141	0	227	182	73.01
73.02	07302	WOUND CARE	0	197	0	175	141	73.02
73.03	07303	SLEEP LAB	0	123	0	166	134	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,918	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	330	0	0	0	88.01
90.00	09000	CLINIC	0	392	0	400	321	90.00
90.01	09001	GERI PSYCH CLINIC	0	691	0	0	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	3,234	910	0	1,108	890	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	956	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	41,280	17,625	42,802	23,962	11,568	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	49	0	0	0	190.00
192.01	19201	GAH - MSO	0	0	0	0	0	192.01
192.02	19202	GAH FOUNDATION	0	38	0	0	0	192.02
194.00	07950	FALCON POINT RENTAL	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN OFFICE	0	346	0	0	0	194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	0	266	0	0	0	194.02
194.03	07953	WELLNESS CENTER	0	0	0	0	0	194.03
194.04	07954	PSYCH CLINIC	0	0	0	0	0	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	0	365	0	0	0	194.05
194.06	07956	LASER CLINIC	0	0	0	0	0	194.06
194.07	07957	PAIN CLINIC	0	0	0	0	0	194.07
194.08	07958	340B PHARMACY	0	0	0	0	0	194.08
194.09	07959	GAH CARDIOLOGY	0	0	0	0	0	194.09
194.10	07960	WIC	0	0	0	0	0	194.10
194.11	07961	PULMONARY CLINIC	0	0	0	0	0	194.11

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
			8.00	9.00	10.00	11.00	13.00	
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0	479	0	0	0	194.12
194.13	07963	PODIATRY	0	0	0	0	0	194.13
194.14	07964	9TH STREET CLINIC	0	0	0	0	0	194.14
194.15	07965	ORTHO CLINIC	0	391	0	0	0	194.15
194.16	07966	GA MEDICAL CLINIC	0	657	0	0	0	194.16
194.17	07967	ELITE PERFORMANCE	0	1,893	0	0	0	194.17
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	41,280	22,109	42,802	23,962	11,568	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00591	ALL OTHER ADMIN & GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY						7.01
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,332					14.00
15.00	01500	PHARMACY	7	25,816				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4	0	22,588			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	230	54	4,735	379,011	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	38	19,713	0	31.00
43.00	04300	NURSERY	0	0	190	25,032	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	404	15,763	0	44.00
46.00	04600	OTHER LONG TERM CARE	58	3	0	275,675	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	781	259	2,985	434,444	0	50.00
51.00	05100	RECOVERY ROOM	26	0	0	31,311	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	59,526	0	52.00
53.00	05300	ANESTHESIOLOGY	57	198	0	21,745	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21	94	5,219	403,682	0	54.00
56.00	05600	RADIOISOTOPE	2	2	0	8,812	0	56.00
60.00	06000	LABORATORY	94	1	1,733	100,098	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	1,425	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	3	3	196	39,511	0	65.00
66.00	06600	PHYSICAL THERAPY	11	19	256	62,206	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,866	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	456	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	723	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,716	0	0	12,383	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,972	0	0	38,819	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	20,218	0	34,397	0	73.00
73.01	07301	CARDIAC REHAB	1	0	66	22,240	0	73.01
73.02	07302	WOUND CARE	5	1	377	22,245	0	73.02
73.03	07303	SLEEP LAB	1	0	195	17,926	0	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	858	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	155	1,999	0	160,378	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	1	101	0	2,848	0	88.01
90.00	09000	CLINIC	16	1	71	41,407	0	90.00
90.01	09001	GERI PSYCH CLINIC	1	1	172	6,220	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	123	26	5,751	156,489	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	19	186	0	86,407	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,304	23,166	22,388	2,484,616	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	4,455	0	190.00
192.01	19201	GAH - MSO	1	0	0	4,761	0	192.01
192.02	19202	GAH FOUNDATION	0	0	0	6,177	0	192.02
194.00	07950	FALCON POINT RENTAL	0	0	0	153	0	194.00
194.01	07951	PHYSICIAN OFFICE	3	1	0	33,627	0	194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	2	96	0	10,313	0	194.02
194.03	07953	WELLNESS CENTER	4	0	0	2,854	0	194.03
194.04	07954	PSYCH CLINIC	0	0	0	6,650	0	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	3	78	0	5,085	0	194.05
194.06	07956	LASER CLINIC	0	0	0	89	0	194.06
194.07	07957	PAIN CLINIC	0	0	0	644	0	194.07
194.08	07958	340B PHARMACY	0	0	0	4,268	0	194.08
194.09	07959	GAH CARDIOLOGY	2	12	0	15,234	0	194.09

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			14.00	15.00	16.00	24.00	25.00	
194.10	07960	WIC	1	0	0	3,742	0	194.10
194.11	07961	PULMONARY CLINIC	0	0	0	8	0	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	1	46	0	3,367	0	194.12
194.13	07963	PODIATRY	0	0	0	1,288	0	194.13
194.14	07964	9TH STREET CLINIC	3	9	0	467	0	194.14
194.15	07965	ORTHO CLINIC	5	2,179	200	39,308	0	194.15
194.16	07966	GA MEDICAL CLINIC	3	229	0	5,894	0	194.16
194.17	07967	ELITE PERFORMANCE	0	0	0	11,779	0	194.17
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	8,332	25,816	22,588	2,644,779	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT			1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE			5.01
5.02	00591	ALL OTHER ADMIN & GENERAL			5.02
7.00	00700	OPERATION OF PLANT			7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY			7.01
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	379,011		30.00
31.00	03100	INTENSIVE CARE UNIT	19,713		31.00
43.00	04300	NURSERY	25,032		43.00
44.00	04400	SKILLED NURSING FACILITY	15,763		44.00
46.00	04600	OTHER LONG TERM CARE	275,675		46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	434,444		50.00
51.00	05100	RECOVERY ROOM	31,311		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	59,526		52.00
53.00	05300	ANESTHESIOLOGY	21,745		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	403,682		54.00
56.00	05600	RADIOISOTOPE	8,812		56.00
60.00	06000	LABORATORY	100,098		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,425		63.00
64.00	06400	INTRAVENOUS THERAPY	0		64.00
65.00	06500	RESPIRATORY THERAPY	39,511		65.00
66.00	06600	PHYSICAL THERAPY	62,206		66.00
67.00	06700	OCCUPATIONAL THERAPY	2,866		67.00
68.00	06800	SPEECH PATHOLOGY	456		68.00
69.00	06900	ELECTROCARDIOLOGY	723		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,383		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,819		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,397		73.00
73.01	07301	CARDIAC REHAB	22,240		73.01
73.02	07302	WOUND CARE	22,245		73.02
73.03	07303	SLEEP LAB	17,926		73.03
73.04	03950	DIETARY EDUCATION	858		73.04
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	160,378		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	2,848		88.01
90.00	09000	CLINIC	41,407		90.00
90.01	09001	GERI PSYCH CLINIC	6,220		90.01
90.02	09002	ORTHO CLINIC	0		90.02
91.00	09100	EMERGENCY	156,489		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	86,407		95.00
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,484,616		118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,455		190.00
192.01	19201	GAH - MSO	4,761		192.01
192.02	19202	GAH FOUNDATION	6,177		192.02
194.00	07950	FALCON POINT RENTAL	153		194.00
194.01	07951	PHYSICIAN OFFICE	33,627		194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	10,313		194.02
194.03	07953	WELLNESS CENTER	2,854		194.03
194.04	07954	PSYCH CLINIC	6,650		194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	5,085		194.05
194.06	07956	LASER CLINIC	89		194.06
194.07	07957	PAIN CLINIC	644		194.07
194.08	07958	340B PHARMACY	4,268		194.08
194.09	07959	GAH CARDIOLOGY	15,234		194.09
194.10	07960	WIC	3,742		194.10
194.11	07961	PULMONARY CLINIC	8		194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	3,367		194.12
194.13	07963	PODIATRY	1,288		194.13

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B Part II Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	Total		
			26.00		
194.14	07964	9TH STREET CLINIC	467		194.14
194.15	07965	ORTHO CLINIC	39,308		194.15
194.16	07966	GA MEDICAL CLINIC	5,894		194.16
194.17	07967	ELITE PERFORMANCE	11,779		194.17
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118-201)	2,644,779		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIIX-OB UNIT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	98,613					1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT	0	9,846				1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP			988,588			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	977	0	0	27,431,461		4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	547	0	0	1,292,439	-2,512,269	5.01
5.02	00591	ALL OTHER ADMIN & GENERAL	22,993	308	355,755	3,898,900	-10,773,973	5.02
7.00	00700	OPERATION OF PLANT	10,651	0	2,142	423,142	-1,790,101	7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY	0	0	0	67,764	-282,176	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	1,977	0	7,270	122,177	-246,654	8.00
9.00	00900	HOUSEKEEPING	541	81	0	368,226	-601,118	9.00
10.00	01000	DIETARY	2,152	0	2,899	198,266	-474,666	10.00
11.00	01100	CAFETERIA	1,056	0	0	280,607	-555,144	11.00
13.00	01300	NURSING ADMINISTRATION	137	0	0	400,440	-768,141	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	460	0	0	0	-103,355	14.00
15.00	01500	PHARMACY	1,071	0	0	471,071	-764,753	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,036	0	75	282,840	-493,096	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,159	6,415	38,167	2,995,672	0	30.00
31.00	03100	INTENSIVE CARE UNIT	887	0	0	212,696	0	31.00
43.00	04300	NURSERY	0	617	0	309,983	0	43.00
44.00	04400	SKILLED NURSING FACILITY	639	0	0	69,688	-110,285	44.00
46.00	04600	OTHER LONG TERM CARE	12,052	0	11,103	1,416,272	-2,241,319	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	13,574	441	137,826	1,640,700	0	50.00
51.00	05100	RECOVERY ROOM	1,542	0	308	285,539	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,922	0	90,941	0	52.00
53.00	05300	ANESTHESIOLOGY	89	62	14,595	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,456	0	209,170	1,462,127	0	54.00
56.00	05600	RADIOISOTOPE	325	0	0	85,239	0	56.00
60.00	06000	LABORATORY	1,916	0	34,561	841,455	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,100	0	11,677	413,644	0	65.00
66.00	06600	PHYSICAL THERAPY	339	0	23,201	1,220,169	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	148,705	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	330	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	31,102	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	821	0	5,650	134,823	0	73.01
73.02	07302	WOUND CARE	1,151	0	0	118,077	0	73.02
73.03	07303	SLEEP LAB	717	0	2,767	104,048	0	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	146	0	29,516	2,333,365	-10,381,653	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	680	40,772	-138,174	88.01
90.00	09000	CLINIC	2,287	0	427	214,802	0	90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0	176,853	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	5,310	0	29,073	1,284,266	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	45,953	1,812,213	-2,913,305	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	98,108	9,846	962,815	25,249,353	-35,150,182	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	284	0	0	0	-3,729	190.00
192.01	19201	GAH - MSO	0	0	0	163,999	-408,084	192.01
192.02	19202	GAH FOUNDATION	221	0	0	40,642	-237,514	192.02
194.00	07950	FALCON POINT RENTAL	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN OFFICE	0	0	20,836	144,602	0	194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	0	0	0	27,151	-861,591	194.02
194.03	07953	WELLNESS CENTER	0	0	0	133,444	-223,683	194.03
194.04	07954	PSYCH CLINIC	0	0	0	175,361	0	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	0	0	0	102,044	0	194.05
194.06	07956	LASER CLINIC	0	0	0	0	0	194.06
194.07	07957	PAIN CLINIC	0	0	0	4,901	0	194.07

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	BLDG & FIIX-OB UNIT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
			1.00	1.01	2.00	4.00	5A.01	
194.08	07958	340B PHARMACY	0	0	0	0	-371,901	194.08
194.09	07959	GAH CARDIOLOGY	0	0	3,402	105,126	0	194.09
194.10	07960	WIC	0	0	0	220,237	-316,999	194.10
194.11	07961	PULMONARY CLINIC	0	0	0	0	0	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0	0	0	121,665	0	194.12
194.13	07963	PODIATRY	0	0	0	2,816	0	194.13
194.14	07964	9TH STREET CLINIC	0	0	0	16,486	0	194.14
194.15	07965	ORTHO CLINIC	0	0	0	332,221	0	194.15
194.16	07966	GA MEDICAL CLINIC	0	0	1,535	81,210	-274,745	194.16
194.17	07967	ELITE PERFORMANCE	0	0	0	510,203	-806,276	194.17
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,294,802	259,318	1,090,659	9,817,305		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.130135	26.337396	1.103249	0.357885		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)				12,828		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)				0.000468		205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	ALL OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-OUTSIDE PROPERTY (SQUARE FEET)	
			5.01	5A.02	5.02	7.00	7.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE	33,498,295					5.01
5.02	00591	ALL OTHER ADMIN & GENERAL	0	-10,773,973	61,379,026			5.02
7.00	00700	OPERATION OF PLANT	0	0	1,790,101	72,983		7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY	0	0	282,176	0	103,690	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	246,654	1,977	0	8.00
9.00	00900	HOUSEKEEPING	0	0	601,118	622	13	9.00
10.00	01000	DIETARY	0	0	474,666	2,152	0	10.00
11.00	01100	CAFETERIA	0	0	555,144	1,056	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	768,141	137	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	103,355	460	0	14.00
15.00	01500	PHARMACY	0	0	764,753	1,071	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	493,096	1,036	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,639,868	0	4,987,842	10,574	0	30.00
31.00	03100	INTENSIVE CARE UNIT	309,575	0	332,792	887	0	31.00
43.00	04300	NURSERY	478,034	0	513,885	617	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	110,285	639	0	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	2,241,319	12,052	0	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,577,566	0	3,845,873	14,015	0	50.00
51.00	05100	RECOVERY ROOM	444,762	0	478,118	1,542	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	186,095	0	200,052	1,922	0	52.00
53.00	05300	ANESTHESIOLOGY	114,413	0	122,994	151	1,590	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,759,335	0	4,041,274	7,456	0	54.00
56.00	05600	RADIOISOTOPE	263,258	0	283,002	325	0	56.00
60.00	06000	LABORATORY	2,234,399	0	2,401,972	1,916	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	113,410	0	121,915	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	636,836	0	684,597	1,100	0	65.00
66.00	06600	PHYSICAL THERAPY	1,876,087	0	2,016,788	339	8,765	66.00
67.00	06700	OCCUPATIONAL THERAPY	209,303	0	225,000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	36,323	0	39,047	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	51,726	0	55,605	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	848,783	0	912,439	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,693,148	0	2,895,126	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,128,197	0	1,212,808	0	0	73.00
73.01	07301	CARDIAC REHAB	215,931	0	232,125	821	0	73.01
73.02	07302	WOUND CARE	287,337	0	308,886	1,151	0	73.02
73.03	07303	SLEEP LAB	253,814	0	272,849	717	0	73.03
73.04	03950	DIETARY EDUCATION	68,263	0	73,383	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	10,381,653	146	40,814	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	138,174	0	1,925	88.01
90.00	09000	CLINIC	357,950	0	384,795	2,287	0	90.00
90.01	09001	GERI PSYCH CLINIC	409,344	0	440,044	0	4,032	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	2,402,580	0	2,582,766	5,310	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	2,913,305	0	8,574	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,596,337	-10,773,973	51,529,917	72,478	65,713	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	3,729	284	0	190.00
192.01	19201	GAH - MSO	0	0	408,084	0	0	192.01
192.02	19202	GAH FOUNDATION	0	0	237,514	221	0	192.02
194.00	07950	FALCON POINT RENTAL	7,301	0	7,849	0	1,928	194.00
194.01	07951	PHYSICIAN OFFICE	808,232	0	868,847	0	2,016	194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	0	0	861,591	0	1,554	194.02
194.03	07953	WELLNESS CENTER	0	0	223,683	0	7,000	194.03
194.04	07954	PSYCH CLINIC	522,598	0	561,791	0	0	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	359,947	0	386,942	0	2,130	194.05
194.06	07956	LASER CLINIC	7,024	0	7,551	0	0	194.06
194.07	07957	PAIN CLINIC	51,098	0	54,930	0	0	194.07
194.08	07958	340B PHARMACY	0	0	371,901	0	0	194.08
194.09	07959	GAH CARDIOLOGY	908,544	0	976,682	0	0	194.09
194.10	07960	WIC	0	0	316,999	0	0	194.10

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	CASHIERING/ACCOUNTS RECEIVABLE (ACCUM. COST)	Reconciliation	ALL OTHER ADMIN & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT-OUTSIDE PROPERTY (SQUARE FEET)	
			5.01	5A.02	5.02	7.00	7.01	
194.11	07961	PULMONARY CLINIC	632	0	679	0	0	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	209,684	0	225,410	0	4,692	194.12
194.13	07963	PODIATRY	102,422	0	110,103	0	0	194.13
194.14	07964	9TH STREET CLINIC	35,597	0	38,267	0	0	194.14
194.15	07965	ORTHO CLINIC	2,888,879	0	3,105,536	0	2,282	194.15
194.16	07966	GA MEDICAL CLINIC	0	0	274,745	0	3,835	194.16
194.17	07967	ELITE PERFORMANCE	0	0	806,276	0	12,540	194.17
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,512,269		10,773,973	2,104,321	331,707	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.074997		0.175532	28.833030	3.199026	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,787		704,317	162,951	3,270	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000232		0.011475	2.232725	0.031536	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRS ING)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT						1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE						5.01
5.02	00591	ALL OTHER ADMIN & GENERAL						5.02
7.00	00700	OPERATION OF PLANT						7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY						7.01
8.00	00800	LAUNDRY & LINEN SERVICE	354,241					8.00
9.00	00900	HOUSEKEEPING	37,879	128,963				9.00
10.00	01000	DIETARY	5,440	2,152	47,246			10.00
11.00	01100	CAFETERIA	9,069	1,056	0	27,079		11.00
13.00	01300	NURSING ADMINISTRATION	0	137	0	496	338,583	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	460	0	0	0	14.00
15.00	01500	PHARMACY	0	1,071	0	199	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,036	0	697	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	63,888	10,574	9,732	4,331	90,076	30.00
31.00	03100	INTENSIVE CARE UNIT	0	887	92	1,143	23,770	31.00
43.00	04300	NURSERY	1,910	617	0	459	9,555	43.00
44.00	04400	SKILLED NURSING FACILITY	19,678	639	1,755	157	3,263	44.00
46.00	04600	OTHER LONG TERM CARE	106,131	12,052	35,667	3,188	66,308	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,857	14,015	0	3,010	62,615	50.00
51.00	05100	RECOVERY ROOM	0	1,542	0	795	16,544	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,482	1,922	0	135	2,803	52.00
53.00	05300	ANESTHESIOLOGY	0	1,741	0	523	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	12,178	7,456	0	2,722	0	54.00
56.00	05600	RADIOISOTOPE	0	325	0	465	0	56.00
60.00	06000	LABORATORY	0	1,916	0	2,150	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,100	0	714	14,858	65.00
66.00	06600	PHYSICAL THERAPY	18,980	9,104	0	3,298	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	186	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	65	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0	821	0	256	5,334	73.01
73.02	07302	WOUND CARE	0	1,151	0	198	4,113	73.02
73.03	07303	SLEEP LAB	0	717	0	188	3,916	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	11,190	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	1,925	0	0	0	88.01
90.00	09000	CLINIC	0	2,287	0	452	9,393	90.00
90.01	09001	GERI PSYCH CLINIC	0	4,032	0	0	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	27,749	5,310	0	1,252	26,035	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,574	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1-117)	354,241	102,809	47,246	27,079	338,583	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	284	0	0	0	190.00
192.01	19201	GAH - MSO	0	0	0	0	0	192.01
192.02	19202	GAH FOUNDATION	0	221	0	0	0	192.02
194.00	07950	FALCON POINT RENTAL	0	0	0	0	0	194.00
194.01	07951	PHYSICIAN OFFICE	0	2,016	0	0	0	194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	0	1,554	0	0	0	194.02
194.03	07953	WELLNESS CENTER	0	0	0	0	0	194.03
194.04	07954	PSYCH CLINIC	0	0	0	0	0	194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	0	2,130	0	0	0	194.05
194.06	07956	LASER CLINIC	0	0	0	0	0	194.06
194.07	07957	PAIN CLINIC	0	0	0	0	0	194.07
194.08	07958	340B PHARMACY	0	0	0	0	0	194.08
194.09	07959	GAH CARDIOLOGY	0	0	0	0	0	194.09

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (DIRECT NRSING)	
			8.00	9.00	10.00	11.00	13.00	
194.10	07960	WIC	0	0	0	0	0	194.10
194.11	07961	PULMONARY CLINIC	0	0	0	0	0	194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	0	2,792	0	0	0	194.12
194.13	07963	PODIATRY	0	0	0	0	0	194.13
194.14	07964	9TH STREET CLINIC	0	0	0	0	0	194.14
194.15	07965	ORTHO CLINIC	0	2,282	0	0	0	194.15
194.16	07966	GA MEDICAL CLINIC	0	3,835	0	0	0	194.16
194.17	07967	ELITE PERFORMANCE	0	11,040	0	0	0	194.17
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	346,953	761,709	638,073	698,157	920,521	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.979426	5.906415	13.505334	25.782230	2.718745	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	41,280	22,109	42,802	23,962	11,568	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.116531	0.171437	0.905939	0.884892	0.034166	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101	CAP REL COSTS-BLDG & FIIX-OB UNIT					1.01
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00580	CASHIERING/ACCOUNTS RECEIVABLE					5.01
5.02	00591	ALL OTHER ADMIN & GENERAL					5.02
7.00	00700	OPERATION OF PLANT					7.00
7.01	00701	OPERATION OF PLANT-OUTSIDE PROPERTY					7.01
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,513,162				14.00
15.00	01500	PHARMACY	3,955	1,440,583			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,052	0	132,941		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	124,461	3,004	27,865		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	225		31.00
43.00	04300	NURSERY	0	0	1,120		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	2,380		44.00
46.00	04600	OTHER LONG TERM CARE	31,654	153	0		46.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	423,196	14,460	17,570		50.00
51.00	05100	RECOVERY ROOM	13,892	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	30,794	11,063	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,401	5,227	30,716		54.00
56.00	05600	RADIOISOTOPE	1,093	121	0		56.00
60.00	06000	LABORATORY	50,709	57	10,200		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	1,640	153	1,155		65.00
66.00	06600	PHYSICAL THERAPY	5,831	1,068	1,505		66.00
67.00	06700	OCCUPATIONAL THERAPY	218	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	41	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	929,431	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,693,148	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,128,197	0		73.00
73.01	07301	CARDIAC REHAB	764	0	390		73.01
73.02	07302	WOUND CARE	2,562	79	2,220		73.02
73.03	07303	SLEEP LAB	420	0	1,150		73.03
73.04	03950	DIETARY EDUCATION	0	0	0		73.04
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	84,150	111,545	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	610	5,646	0		88.01
90.00	09000	CLINIC	8,670	47	415		90.00
90.01	09001	GERI PSYCH CLINIC	802	61	1,010		90.01
90.02	09002	ORTHO CLINIC	0	0	0		90.02
91.00	09100	EMERGENCY	66,713	1,440	33,840		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	10,256	10,360	0		95.00
		SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,498,463	1,292,681	131,761		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
192.01	19201	GAH - MSO	797	0	0		192.01
192.02	19202	GAH FOUNDATION	40	0	0		192.02
194.00	07950	FALCON POINT RENTAL	0	0	0		194.00
194.01	07951	PHYSICIAN OFFICE	1,592	83	0		194.01
194.02	07952	PLASTIC SURG & DR. CHUNG	1,246	5,382	0		194.02
194.03	07953	WELLNESS CENTER	1,976	0	0		194.03
194.04	07954	PSYCH CLINIC	40	0	0		194.04
194.05	07955	MAHOMET SPECIALTY CLINIC	1,467	4,379	0		194.05
194.06	07956	LASER CLINIC	3	0	0		194.06
194.07	07957	PAIN CLINIC	0	0	0		194.07
194.08	07958	340B PHARMACY	0	0	0		194.08
194.09	07959	GAH CARDIOLOGY	1,061	645	0		194.09

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-1 | Date/Time Prepared: 2/23/2016 6:02 pm

		Cost Center Description	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)		
			14.00	15.00	16.00		
194.10	07960	WIC	280	0	0		194.10
194.11	07961	PULMONARY CLINIC	0	0	0		194.11
194.12	07962	FAMILY HEALTHCARE OF POTOMAC	365	2,573	0		194.12
194.13	07963	PODIATRY	0	0	0		194.13
194.14	07964	9TH STREET CLINIC	1,641	500	0		194.14
194.15	07965	ORTHO CLINIC	2,813	121,587	1,180		194.15
194.16	07966	GA MEDICAL CLINIC	1,378	12,753	0		194.16
194.17	07967	ELITE PERFORMANCE	0	0	0		194.17
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	137,477	941,449	633,673		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.030461	0.653519	4.766573		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	8,332	25,816	22,588		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.001846	0.017921	0.169910		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet B-2 | Date/Time Prepared: 2/23/2016 6:02 pm

		Description	Worksheet Part	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		IV THERAPY RECLASS	1	30.00	-45,108	7.00
8.00		IV THERAPY RECLASS	1	64.00	45,108	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,874,730		6,874,730	0	6,874,730	30.00
31.00	03100	INTENSIVE CARE UNIT	518,430		518,430	0	518,430	31.00
43.00	04300	NURSERY	670,544		670,544	0	670,544	43.00
44.00	04400	SKILLED NURSING FACILITY	219,080		219,080	0	219,080	44.00
46.00	04600	OTHER LONG TERM CARE	3,902,597		3,902,597	0	3,902,597	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,397,849		5,397,849	0	5,397,849	50.00
51.00	05100	RECOVERY ROOM	681,511		681,511	0	681,511	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	327,223		327,223	0	327,223	52.00
53.00	05300	ANESTHESIOLOGY	185,958		185,958	0	185,958	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,241,943		5,241,943	0	5,241,943	54.00
56.00	05600	RADIOISOTOPE	356,070		356,070	0	356,070	56.00
60.00	06000	LABORATORY	2,995,789		2,995,789	0	2,995,789	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	143,315		143,315	0	143,315	63.00
64.00	06400	INTRAVENOUS THERAPY	45,108		45,108	0	45,108	64.00
65.00	06500	RESPIRATORY THERAPY	907,438	0	907,438	0	907,438	65.00
66.00	06600	PHYSICAL THERAPY	2,574,054	0	2,574,054	0	2,574,054	66.00
67.00	06700	OCCUPATIONAL THERAPY	269,297	0	269,297	0	269,297	67.00
68.00	06800	SPEECH PATHOLOGY	45,901	0	45,901	0	45,901	68.00
69.00	06900	ELECTROCARDIOLOGY	67,042		67,042	0	67,042	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,100,912		1,100,912	0	1,100,912	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,485,353		3,485,353	0	3,485,353	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,162,993		2,162,993	0	2,162,993	73.00
73.01	07301	CARDIAC REHAB	324,375		324,375	0	324,375	73.01
73.02	07302	WOUND CARE	430,089		430,089	0	430,089	73.02
73.03	07303	SLEEP LAB	366,640		366,640	0	366,640	73.03
73.04	03950	DIETARY EDUCATION	86,264		86,264	0	86,264	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,480,283		12,480,283	0	12,480,283	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	183,665		183,665	0	183,665	88.01
90.00	09000	CLINIC	571,252		571,252	0	571,252	90.00
90.01	09001	GERI PSYCH CLINIC	558,877		558,877	0	558,877	90.01
90.02	09002	ORTHO CLINIC	0		0	0	0	90.02
91.00	09100	EMERGENCY	3,515,103		3,515,103	0	3,515,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	815,361		815,361		815,361	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,492,115		3,492,115	0	3,492,115	95.00
200.00		Subtotal (see instructions)	60,997,161	0	60,997,161	0	60,997,161	200.00
201.00		Less Observation Beds	815,361		815,361		815,361	201.00
202.00		Total (see instructions)	60,181,800	0	60,181,800	0	60,181,800	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,203,848		5,203,848			30.00
31.00	03100	INTENSIVE CARE UNIT	151,049		151,049			31.00
43.00	04300	NURSERY	676,530		676,530			43.00
44.00	04400	SKILLED NURSING FACILITY	172,267		172,267			44.00
46.00	04600	OTHER LONG TERM CARE	3,116,251		3,116,251			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,782,322	12,202,124	17,984,446	0.300140	0.000000	50.00
51.00	05100	RECOVERY ROOM	581,032	2,274,903	2,855,935	0.238630	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,891,957	341,244	2,233,201	0.146526	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	36,833	294,356	331,189	0.561486	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,304,244	23,572,869	24,877,113	0.210713	0.000000	54.00
56.00	05600	RADIOISOTOPE	42,841	1,435,359	1,478,200	0.240881	0.000000	56.00
60.00	06000	LABORATORY	1,695,800	15,320,769	17,016,569	0.176051	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	240,746	192,875	433,621	0.330508	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	8,486	648,396	656,882	0.068670	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,070,451	1,246,850	4,317,301	0.210186	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	829,223	5,893,062	6,722,285	0.382914	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	813,795	172,371	986,166	0.273075	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	34,038	76,117	110,155	0.416695	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	113,360	1,052,903	1,166,263	0.057484	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,267,627	2,959,496	6,227,123	0.176793	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,062,121	643,770	6,705,891	0.519745	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,048,106	7,976,759	13,024,865	0.166066	0.000000	73.00
73.01	07301	CARDIAC REHAB	0	425,758	425,758	0.761876	0.000000	73.01
73.02	07302	WOUND CARE	2,356	530,357	532,713	0.807356	0.000000	73.02
73.03	07303	SLEEP LAB	0	1,317,612	1,317,612	0.278261	0.000000	73.03
73.04	03950	DIETARY EDUCATION	47,881	32,884	80,765	1.068086	0.000000	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,861	11,090,420	11,099,281			88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	127,085	127,085			88.01
90.00	09000	CLINIC	0	673,063	673,063	0.848735	0.000000	90.00
90.01	09001	GERI PSYCH CLINIC	0	465,937	465,937	1.199469	0.000000	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	15,711	9,685,805	9,701,516	0.362325	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	21,020	520,922	541,942	1.504517	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,846,417	5,846,417	0.597309	0.000000	95.00
200.00		Subtotal (see instructions)	40,238,756	107,020,483	147,259,239			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	40,238,756	107,020,483	147,259,239			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 6:02 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
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	CARDIAC REHAB	0.000000		73.01
73.02	07302	WOUND CARE	0.000000		73.02
73.03	07303	SLEEP LAB	0.000000		73.03
73.04	03950	DIETARY EDUCATION	0.000000		73.04
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)			88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	GERI PSYCH CLINIC	0.000000		90.01
90.02	09002	ORTHO 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			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 6:02 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	6,874,730		6,874,730	0	6,874,730	30.00
31.00	03100	INTENSIVE CARE UNIT	518,430		518,430	0	518,430	31.00
43.00	04300	NURSERY	670,544		670,544	0	670,544	43.00
44.00	04400	SKILLED NURSING FACILITY	219,080		219,080	0	219,080	44.00
46.00	04600	OTHER LONG TERM CARE	3,902,597		3,902,597	0	3,902,597	46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,397,849		5,397,849	0	5,397,849	50.00
51.00	05100	RECOVERY ROOM	681,511		681,511	0	681,511	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	327,223		327,223	0	327,223	52.00
53.00	05300	ANESTHESIOLOGY	185,958		185,958	0	185,958	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,241,943		5,241,943	0	5,241,943	54.00
56.00	05600	RADIOISOTOPE	356,070		356,070	0	356,070	56.00
60.00	06000	LABORATORY	2,995,789		2,995,789	0	2,995,789	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	143,315		143,315	0	143,315	63.00
64.00	06400	INTRAVENOUS THERAPY	45,108		45,108	0	45,108	64.00
65.00	06500	RESPIRATORY THERAPY	907,438	0	907,438	0	907,438	65.00
66.00	06600	PHYSICAL THERAPY	2,574,054	0	2,574,054	0	2,574,054	66.00
67.00	06700	OCCUPATIONAL THERAPY	269,297	0	269,297	0	269,297	67.00
68.00	06800	SPEECH PATHOLOGY	45,901	0	45,901	0	45,901	68.00
69.00	06900	ELECTROCARDIOLOGY	67,042		67,042	0	67,042	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,100,912		1,100,912	0	1,100,912	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,485,353		3,485,353	0	3,485,353	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,162,993		2,162,993	0	2,162,993	73.00
73.01	07301	CARDIAC REHAB	324,375		324,375	0	324,375	73.01
73.02	07302	WOUND CARE	430,089		430,089	0	430,089	73.02
73.03	07303	SLEEP LAB	366,640		366,640	0	366,640	73.03
73.04	03950	DIETARY EDUCATION	86,264		86,264	0	86,264	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	12,480,283		12,480,283	0	12,480,283	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	183,665		183,665	0	183,665	88.01
90.00	09000	CLINIC	571,252		571,252	0	571,252	90.00
90.01	09001	GERI PSYCH CLINIC	558,877		558,877	0	558,877	90.01
90.02	09002	ORTHO CLINIC	0		0	0	0	90.02
91.00	09100	EMERGENCY	3,515,103		3,515,103	0	3,515,103	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	815,361		815,361		815,361	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,492,115		3,492,115	0	3,492,115	95.00
200.00		Subtotal (see instructions)	60,997,161	0	60,997,161	0	60,997,161	200.00
201.00		Less Observation Beds	815,361		815,361		815,361	201.00
202.00		Total (see instructions)	60,181,800	0	60,181,800	0	60,181,800	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 6:02 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,203,848		5,203,848			30.00
31.00	03100	INTENSIVE CARE UNIT	151,049		151,049			31.00
43.00	04300	NURSERY	676,530		676,530			43.00
44.00	04400	SKILLED NURSING FACILITY	172,267		172,267			44.00
46.00	04600	OTHER LONG TERM CARE	3,116,251		3,116,251			46.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,782,322	12,202,124	17,984,446	0.300140	0.000000	50.00
51.00	05100	RECOVERY ROOM	581,032	2,274,903	2,855,935	0.238630	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,891,957	341,244	2,233,201	0.146526	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	36,833	294,356	331,189	0.561486	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,304,244	23,572,869	24,877,113	0.210713	0.000000	54.00
56.00	05600	RADIOISOTOPE	42,841	1,435,359	1,478,200	0.240881	0.000000	56.00
60.00	06000	LABORATORY	1,695,800	15,320,769	17,016,569	0.176051	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	240,746	192,875	433,621	0.330508	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	8,486	648,396	656,882	0.068670	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	3,070,451	1,246,850	4,317,301	0.210186	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	829,223	5,893,062	6,722,285	0.382914	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	813,795	172,371	986,166	0.273075	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	34,038	76,117	110,155	0.416695	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	113,360	1,052,903	1,166,263	0.057484	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,267,627	2,959,496	6,227,123	0.176793	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,062,121	643,770	6,705,891	0.519745	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,048,106	7,976,759	13,024,865	0.166066	0.000000	73.00
73.01	07301	CARDIAC REHAB	0	425,758	425,758	0.761876	0.000000	73.01
73.02	07302	WOUND CARE	2,356	530,357	532,713	0.807356	0.000000	73.02
73.03	07303	SLEEP LAB	0	1,317,612	1,317,612	0.278261	0.000000	73.03
73.04	03950	DIETARY EDUCATION	47,881	32,884	80,765	1.068086	0.000000	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	8,861	11,090,420	11,099,281	1.124423	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	127,085	127,085	1.445214	0.000000	88.01
90.00	09000	CLINIC	0	673,063	673,063	0.848735	0.000000	90.00
90.01	09001	GERI PSYCH CLINIC	0	465,937	465,937	1.199469	0.000000	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0.000000	0.000000	90.02
91.00	09100	EMERGENCY	15,711	9,685,805	9,701,516	0.362325	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	21,020	520,922	541,942	1.504517	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	5,846,417	5,846,417	0.597309	0.000000	95.00
200.00		Subtotal (see instructions)	40,238,756	107,020,483	147,259,239			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	40,238,756	107,020,483	147,259,239			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet C Part I Date/Time Prepared: 2/23/2016 6:02 pm

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
46.00	04600	OTHER LONG TERM CARE			46.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
60.00	06000	LABORATORY	0.000000		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	CARDIAC REHAB	0.000000		73.01
73.02	07302	WOUND CARE	0.000000		73.02
73.03	07303	SLEEP LAB	0.000000		73.03
73.04	03950	DIETARY EDUCATION	0.000000		73.04
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000		88.01
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	GERI PSYCH CLINIC	0.000000		90.01
90.02	09002	ORTHO 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			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
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: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part II Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	434,444	17,984,446	0.024157	2,320,534	56,057	50.00
51.00	05100	RECOVERY ROOM	31,311	2,855,935	0.010963	230,500	2,527	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	59,526	2,233,201	0.026655	0	0	52.00
53.00	05300	ANESTHESIOLOGY	21,745	331,189	0.065657	32,328	2,123	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	403,682	24,877,113	0.016227	685,086	11,117	54.00
56.00	05600	RADIOISOTOPE	8,812	1,478,200	0.005961	33,930	202	56.00
60.00	06000	LABORATORY	100,098	17,016,569	0.005882	789,710	4,645	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,425	433,621	0.003286	168,816	555	63.00
64.00	06400	INTRAVENOUS THERAPY	0	656,882	0.000000	2,296	0	64.00
65.00	06500	RESPIRATORY THERAPY	39,511	4,317,301	0.009152	1,469,577	13,450	65.00
66.00	06600	PHYSICAL THERAPY	62,206	6,722,285	0.009254	187,555	1,736	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,866	986,166	0.002906	204,666	595	67.00
68.00	06800	SPEECH PATHOLOGY	456	110,155	0.004140	7,580	31	68.00
69.00	06900	ELECTROCARDIOLOGY	723	1,166,263	0.000620	68,228	42	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,383	6,227,123	0.001989	948,040	1,886	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,819	6,705,891	0.005789	2,999,107	17,362	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	34,397	13,024,865	0.002641	1,972,458	5,209	73.00
73.01	07301	CARDIAC REHAB	22,240	425,758	0.052236	0	0	73.01
73.02	07302	WOUND CARE	22,245	532,713	0.041758	0	0	73.02
73.03	07303	SLEEP LAB	17,926	1,317,612	0.013605	0	0	73.03
73.04	03950	DIETARY EDUCATION	858	80,765	0.010623	15,938	169	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	160,378	11,099,281	0.014449	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	2,848	127,085	0.022410	0	0	88.01
90.00	09000	CLINIC	41,407	673,063	0.061520	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	6,220	465,937	0.013349	0	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0.000000	0	0	90.02
91.00	09100	EMERGENCY	156,489	9,701,516	0.016130	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	55,258	541,942	0.101963	11,555	1,178	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,738,273	132,092,877		12,147,904	118,884	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0	0	0	0	0	73.01
73.02	07302	WOUND CARE	0	0	0	0	0	73.02
73.03	07303	SLEEP LAB	0	0	0	0	0	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0	0	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	17,984,446	0.000000	0.000000	2,320,534	50.00
51.00	05100	RECOVERY ROOM	0	2,855,935	0.000000	0.000000	230,500	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,233,201	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	331,189	0.000000	0.000000	32,328	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,877,113	0.000000	0.000000	685,086	54.00
56.00	05600	RADIOISOTOPE	0	1,478,200	0.000000	0.000000	33,930	56.00
60.00	06000	LABORATORY	0	17,016,569	0.000000	0.000000	789,710	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	433,621	0.000000	0.000000	168,816	63.00
64.00	06400	INTRAVENOUS THERAPY	0	656,882	0.000000	0.000000	2,296	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,317,301	0.000000	0.000000	1,469,577	65.00
66.00	06600	PHYSICAL THERAPY	0	6,722,285	0.000000	0.000000	187,555	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	986,166	0.000000	0.000000	204,666	67.00
68.00	06800	SPEECH PATHOLOGY	0	110,155	0.000000	0.000000	7,580	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,166,263	0.000000	0.000000	68,228	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,227,123	0.000000	0.000000	948,040	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,705,891	0.000000	0.000000	2,999,107	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,024,865	0.000000	0.000000	1,972,458	73.00
73.01	07301	CARDIAC REHAB	0	425,758	0.000000	0.000000	0	73.01
73.02	07302	WOUND CARE	0	532,713	0.000000	0.000000	0	73.02
73.03	07303	SLEEP LAB	0	1,317,612	0.000000	0.000000	0	73.03
73.04	03950	DIETARY EDUCATION	0	80,765	0.000000	0.000000	15,938	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	11,099,281	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	127,085	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	673,063	0.000000	0.000000	0	90.00
90.01	09001	GERI PSYCH CLINIC	0	465,937	0.000000	0.000000	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	9,701,516	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	541,942	0.000000	0.000000	11,555	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	132,092,877			12,147,904	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01	07301	CARDIAC REHAB	0	0	0		73.01
73.02	07302	WOUND CARE	0	0	0		73.02
73.03	07303	SLEEP LAB	0	0	0		73.03
73.04	03950	DIETARY EDUCATION	0	0	0		73.04
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0		88.01
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0		90.01
90.02	09002	ORTHO 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
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.300140	0	3,479,346	0	0	50.00
51.00	05100	RECOVERY ROOM	0.238630	0	700,090	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.146526	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.561486	0	189,981	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210713	0	6,777,108	84	0	54.00
56.00	05600	RADIOISOTOPE	0.240881	0	576,484	207	0	56.00
60.00	06000	LABORATORY	0.176051	0	5,692,157	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.330508	0	88,684	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.068670	0	231,107	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.210186	0	461,186	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.382914	0	1,677,111	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273075	0	87,219	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.416695	0	15,420	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057484	0	400,257	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176793	0	696,369	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.519745	0	300,868	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166066	0	2,510,872	2,380	0	73.00
73.01	07301	CARDIAC REHAB	0.761876	0	231,355	0	0	73.01
73.02	07302	WOUND CARE	0.807356	0	261,388	0	0	73.02
73.03	07303	SLEEP LAB	0.278261	0	304,925	0	0	73.03
73.04	03950	DIETARY EDUCATION	1.068086	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000				0	88.01
90.00	09000	CLINIC	0.848735	0	329,202	3,504	0	90.00
90.01	09001	GERI PSYCH CLINIC	1.199469	0	387,192	0	0	90.01
90.02	09002	ORTHO CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.362325	0	2,499,018	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.504517	0	190,388	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.597309		0			95.00
200.00		Subtotal (see instructions)		0	28,087,727	6,175	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	28,087,727	6,175	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,044,291	0		50.00
51.00	05100	RECOVERY ROOM	167,062	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	106,672	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,428,025	18		54.00
56.00	05600	RADIOISOTOPE	138,864	50		56.00
60.00	06000	LABORATORY	1,002,110	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	29,311	0		63.00
64.00	06400	INTRAVENOUS THERAPY	15,870	0		64.00
65.00	06500	RESPIRATORY THERAPY	96,935	0		65.00
66.00	06600	PHYSICAL THERAPY	642,189	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	23,817	0		67.00
68.00	06800	SPEECH PATHOLOGY	6,425	0		68.00
69.00	06900	ELECTROCARDIOLOGY	23,008	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	123,113	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	156,375	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	416,970	395		73.00
73.01	07301	CARDIAC REHAB	176,264	0		73.01
73.02	07302	WOUND CARE	211,033	0		73.02
73.03	07303	SLEEP LAB	84,849	0		73.03
73.04	03950	DIETARY EDUCATION	0	0		73.04
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0		88.01
90.00	09000	CLINIC	279,405	2,974		90.00
90.01	09001	GERI PSYCH CLINIC	464,425	0		90.01
90.02	09002	ORTHO CLINIC	0	0		90.02
91.00	09100	EMERGENCY	905,457	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	286,442	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	7,828,912	3,437		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	7,828,912	3,437		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141317 | Component CCN: 14Z317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.300140	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.238630	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.146526	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.561486	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210713	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.240881	0	0	0	0	56.00
60.00	06000	LABORATORY	0.176051	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.330508	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.068670	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.210186	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.382914	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273075	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.416695	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057484	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176793	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.519745	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166066	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0.761876	0	0	0	0	73.01
73.02	07302	WOUND CARE	0.807356	0	0	0	0	73.02
73.03	07303	SLEEP LAB	0.278261	0	0	0	0	73.03
73.04	03950	DIETARY EDUCATION	1.068086	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000				0	88.01
90.00	09000	CLINIC	0.848735	0	0	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	1.199469	0	0	0	0	90.01
90.02	09002	ORTHO CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.362325	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.504517	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.597309		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141317 | Component CCN: 14Z317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	CARDIAC REHAB	0	0		73.01
73.02	07302	WOUND CARE	0	0		73.02
73.03	07303	SLEEP LAB	0	0		73.03
73.04	03950	DIETARY EDUCATION	0	0		73.04
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09001	GERI PSYCH CLINIC	0	0		90.01
90.02	09002	ORTHO 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
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141317 | Component CCN: 145979 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0	0	0	0	0	73.01
73.02	07302	WOUND CARE	0	0	0	0	0	73.02
73.03	07303	SLEEP LAB	0	0	0	0	0	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0	0	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141317 | Component CCN: 145979 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Skilled Nursing Facility | PPS

		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	17,984,446	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	2,855,935	0.000000	0.000000	2,302	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,233,201	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	331,189	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,877,113	0.000000	0.000000	7,269	54.00
56.00	05600	RADIOISOTOPE	0	1,478,200	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	17,016,569	0.000000	0.000000	23,467	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	433,621	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	656,882	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,317,301	0.000000	0.000000	2,659	65.00
66.00	06600	PHYSICAL THERAPY	0	6,722,285	0.000000	0.000000	109,307	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	986,166	0.000000	0.000000	198,011	67.00
68.00	06800	SPEECH PATHOLOGY	0	110,155	0.000000	0.000000	7,942	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,166,263	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,227,123	0.000000	0.000000	4,270	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,705,891	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,024,865	0.000000	0.000000	36,924	73.00
73.01	07301	CARDIAC REHAB	0	425,758	0.000000	0.000000	0	73.01
73.02	07302	WOUND CARE	0	532,713	0.000000	0.000000	0	73.02
73.03	07303	SLEEP LAB	0	1,317,612	0.000000	0.000000	0	73.03
73.04	03950	DIETARY EDUCATION	0	80,765	0.000000	0.000000	2,964	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	11,099,281	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	127,085	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	673,063	0.000000	0.000000	0	90.00
90.01	09001	GERI PSYCH CLINIC	0	465,937	0.000000	0.000000	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	9,701,516	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	541,942	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	132,092,877			395,115	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141317 | Component CCN: 145979 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01	07301	CARDIAC REHAB	0	0	0		73.01
73.02	07302	WOUND CARE	0	0	0		73.02
73.03	07303	SLEEP LAB	0	0	0		73.03
73.04	03950	DIETARY EDUCATION	0	0	0		73.04
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0		88.01
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0		90.01
90.02	09002	ORTHO 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
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141317 | Component CCN: 145979 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.300140	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.238630	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.146526	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.561486	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210713	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.240881	0	0	0	0	56.00
60.00	06000	LABORATORY	0.176051	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.330508	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.068670	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.210186	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.382914	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273075	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.416695	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057484	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176793	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.519745	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166066	0	0	552	0	73.00
73.01	07301	CARDIAC REHAB	0.761876	0	0	0	0	73.01
73.02	07302	WOUND CARE	0.807356	0	0	0	0	73.02
73.03	07303	SLEEP LAB	0.278261	0	0	0	0	73.03
73.04	03950	DIETARY EDUCATION	1.068086	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000				0	88.01
90.00	09000	CLINIC	0.848735	0	0	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	1.199469	0	0	0	0	90.01
90.02	09002	ORTHO CLINIC	0.000000	0	0	0	0	90.02
91.00	09100	EMERGENCY	0.362325	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.504517	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.597309		0			95.00
200.00		Subtotal (see instructions)		0	0	552	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	552	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141317 | Component CCN: 145979 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part V | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
60.00	06000	LABORATORY	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	92		73.00
73.01	07301	CARDIAC REHAB	0	0		73.01
73.02	07302	WOUND CARE	0	0		73.02
73.03	07303	SLEEP LAB	0	0		73.03
73.04	03950	DIETARY EDUCATION	0	0		73.04
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0		88.01
90.00	09000	CLINIC	0	0		90.00
90.01	09001	GERI PSYCH CLINIC	0	0		90.01
90.02	09002	ORTHO 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
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	92		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	92		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141317 | Component CCN: 145979 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 6:02 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	CARDIAC REHAB	0	0	0	0	0	73.01
73.02	07302	WOUND CARE	0	0	0	0	0	73.02
73.03	07303	SLEEP LAB	0	0	0	0	0	73.03
73.04	03950	DIETARY EDUCATION	0	0	0	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0	0	0	88.01
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0	0	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0	0	0	90.02
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141317 | Component CCN: 145979 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 6:02 pm

Title XIX | Skilled Nursing Facility | PPS

		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	17,984,446	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	2,855,935	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,233,201	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	331,189	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,877,113	0.000000	0.000000	0	54.00
56.00	05600	RADIOISOTOPE	0	1,478,200	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	17,016,569	0.000000	0.000000	0	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	433,621	0.000000	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	656,882	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	4,317,301	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	6,722,285	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	986,166	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	110,155	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,166,263	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,227,123	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,705,891	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,024,865	0.000000	0.000000	0	73.00
73.01	07301	CARDIAC REHAB	0	425,758	0.000000	0.000000	0	73.01
73.02	07302	WOUND CARE	0	532,713	0.000000	0.000000	0	73.02
73.03	07303	SLEEP LAB	0	1,317,612	0.000000	0.000000	0	73.03
73.04	03950	DIETARY EDUCATION	0	80,765	0.000000	0.000000	0	73.04
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	11,099,281	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	127,085	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	673,063	0.000000	0.000000	0	90.00
90.01	09001	GERI PSYCH CLINIC	0	465,937	0.000000	0.000000	0	90.01
90.02	09002	ORTHO CLINIC	0	0	0.000000	0.000000	0	90.02
91.00	09100	EMERGENCY	0	9,701,516	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	541,942	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	132,092,877			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141317 | Component CCN: 145979 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D Part IV | Date/Time Prepared: 2/23/2016 6:02 pm

Title XIX | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
73.01	07301	CARDIAC REHAB	0	0	0		73.01
73.02	07302	WOUND CARE	0	0	0		73.02
73.03	07303	SLEEP LAB	0	0	0		73.03
73.04	03950	DIETARY EDUCATION	0	0	0		73.04
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0	0	0		88.01
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	GERI PSYCH CLINIC	0	0	0		90.01
90.02	09002	ORTHO 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
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,263	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,627	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)	2,244	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	133	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)	467	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	22	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)	14	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,013	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)	131	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)	323	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20.00
21.00	Total general inpatient routine service cost (see instructions)	6,874,730	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)	2,960	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,884	25.00
26.00	Total swing-bed cost (see instructions)	1,282,172	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,592,558	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)	5,592,558	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)	2,128.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,156,555	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)	2,156,555	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	518,430	61	8,498.85	43	365,451	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)	3,649,169	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,171,175	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)	278,883	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	687,628	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	966,511	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)	383	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	2,128.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	815,361	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	379,011	5,592,558	0.067771	815,361	55,258	90.00
91.00	Nursing School cost	0	5,592,558	0.000000	815,361	0	91.00
92.00	Allied health cost	0	5,592,558	0.000000	815,361	0	92.00
93.00	All other Medical Education	0	5,592,558	0.000000	815,361	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141317	Period: From 10/01/2014	Worksheet D-1
Component CCN: 145979	To 09/30/2015	Date/Time Prepared: 2/23/2016 6:02 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)	585	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	585	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)	585	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)	569	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	219,080	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)	219,080	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)	219,080	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: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1

Component CCN: 145979 | Date/Time Prepared: 2/23/2016 6:02 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)	219,080	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	374.50	71.00
72.00	Program routine service cost (line 9 x line 71)	213,091	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)	213,091	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)	213,091	83.00
84.00	Program inpatient ancillary services (see instructions)	116,060	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)	329,151	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: 141317 | Component CCN: 145979 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 6:02 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: 141317	Period: From 10/01/2014	Worksheet D-1
Component CCN: 145979	To 09/30/2015	Date/Time Prepared: 2/23/2016 6:02 pm
Title XIX	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)	585	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	585	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)	585	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)	0	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)	317	15.00
16.00	Nursery days (title V or XIX only)	113	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	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	219,080	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)	219,080	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)	219,080	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: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1

Component CCN: 145979 | Date/Time Prepared: 2/23/2016 6:02 pm

Title XIX | 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)	219,080	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	374.50	71.00
72.00	Program routine service cost (line 9 x line 71)	0	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)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	15,763	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	26.95	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)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	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)	0	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: 141317 | Component CCN: 145979 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-1 | Date/Time Prepared: 2/23/2016 6:02 pm

Title XIX | 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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3 | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,125,768		30.00
31.00	03100	INTENSIVE CARE UNIT		105,503		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.300140	2,320,534	696,485	50.00
51.00	05100	RECOVERY ROOM	0.238630	230,500	55,004	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.146526	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.561486	32,328	18,152	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210713	685,086	144,357	54.00
56.00	05600	RADIOISOTOPE	0.240881	33,930	8,173	56.00
60.00	06000	LABORATORY	0.176051	789,710	139,029	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.330508	168,816	55,795	63.00
64.00	06400	INTRAVENOUS THERAPY	0.068670	2,296	158	64.00
65.00	06500	RESPIRATORY THERAPY	0.210186	1,469,577	308,885	65.00
66.00	06600	PHYSICAL THERAPY	0.382914	187,555	71,817	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273075	204,666	55,889	67.00
68.00	06800	SPEECH PATHOLOGY	0.416695	7,580	3,159	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057484	68,228	3,922	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176793	948,040	167,607	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.519745	2,999,107	1,558,771	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166066	1,972,458	327,558	73.00
73.01	07301	CARDIAC REHAB	0.761876	0	0	73.01
73.02	07302	WOUND CARE	0.807356	0	0	73.02
73.03	07303	SLEEP LAB	0.278261	0	0	73.03
73.04	03950	DIETARY EDUCATION	1.068086	15,938	17,023	73.04
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000		0	88.01
90.00	09000	CLINIC	0.848735	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	1.199469	0	0	90.01
90.02	09002	ORTHO CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.362325	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.504517	11,555	17,385	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		12,147,904	3,649,169	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)		12,147,904		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3

Component CCN: 14Z317 | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.300140	0	0	50.00
51.00	05100	RECOVERY ROOM	0.238630	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.146526	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.561486	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210713	40,757	8,588	54.00
56.00	05600	RADIOISOTOPE	0.240881	0	0	56.00
60.00	06000	LABORATORY	0.176051	89,261	15,714	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.330508	3,084	1,019	63.00
64.00	06400	INTRAVENOUS THERAPY	0.068670	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.210186	173,270	36,419	65.00
66.00	06600	PHYSICAL THERAPY	0.382914	104,580	40,045	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273075	114,477	31,261	67.00
68.00	06800	SPEECH PATHOLOGY	0.416695	780	325	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057484	4,073	234	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176793	233,722	41,320	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.519745	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166066	401,887	66,740	73.00
73.01	07301	CARDIAC REHAB	0.761876	0	0	73.01
73.02	07302	WOUND CARE	0.807356	0	0	73.02
73.03	07303	SLEEP LAB	0.278261	0	0	73.03
73.04	03950	DIETARY EDUCATION	1.068086	0	0	73.04
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000		0	88.01
90.00	09000	CLINIC	0.848735	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	1.199469	0	0	90.01
90.02	09002	ORTHO CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.362325	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.504517	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,165,891	241,665	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,165,891		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet D-3

Component CCN: 145979 | Date/Time Prepared: 2/23/2016 6:02 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	0.300140	0	0	50.00
51.00	05100	RECOVERY ROOM	0.238630	2,302	549	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.146526	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.561486	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.210713	7,269	1,532	54.00
56.00	05600	RADIOISOTOPE	0.240881	0	0	56.00
60.00	06000	LABORATORY	0.176051	23,467	4,131	60.00
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.330508	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.068670	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.210186	2,659	559	65.00
66.00	06600	PHYSICAL THERAPY	0.382914	109,307	41,855	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.273075	198,011	54,072	67.00
68.00	06800	SPEECH PATHOLOGY	0.416695	7,942	3,309	68.00
69.00	06900	ELECTROCARDIOLOGY	0.057484	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.176793	4,270	755	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.519745	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.166066	36,924	6,132	73.00
73.01	07301	CARDIAC REHAB	0.761876	0	0	73.01
73.02	07302	WOUND CARE	0.807356	0	0	73.02
73.03	07303	SLEEP LAB	0.278261	0	0	73.03
73.04	03950	DIETARY EDUCATION	1.068086	2,964	3,166	73.04
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC (RHC)	0.000000		0	88.01
90.00	09000	CLINIC	0.848735	0	0	90.00
90.01	09001	GERI PSYCH CLINIC	1.199469	0	0	90.01
90.02	09002	ORTHO CLINIC	0.000000	0	0	90.02
91.00	09100	EMERGENCY	0.362325	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.504517	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		395,115	116,060	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)		395,115		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141317	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/23/2016 6:02 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,832,349	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7,832,349	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 chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	7,910,672	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)	50,033	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,505,130	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)	3,355,509	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,355,509	30.00
31.00	Primary payer payments	870	31.00
32.00	Subtotal (line 30 minus line 31)	3,354,639	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)	248,787	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	161,712	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	248,787	36.00
37.00	Subtotal (see instructions)	3,516,351	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)	3,516,351	40.00
40.01	Sequestration adjustment (see instructions)	70,327	40.01
41.00	Interim payments	3,448,389	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-2,365	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141317 Component CCN: 145979	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/23/2016 6:02 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	92	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)	92	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	552	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)	552	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	552	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	460	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)	92	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)	92	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)	92	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	92	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)	92	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)	92	40.00
40.01	Sequestration adjustment (see instructions)	2	40.01
41.00	Interim payments	97	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-7	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: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2016 6:02 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		4,406,272		4,127,799	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	05/07/2015	356,403		0	3.01
3.02		09/22/2015	394,397		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	05/07/2015	224,864	3.50
3.51			0	09/22/2015	454,546	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)		750,800		-679,410	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)		5,157,072		3,448,389	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		615,435		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		2,365	6.02
7.00	Total Medicare program liability (see instructions)		5,772,507		3,446,024	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: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2016 6:02 pm

Component CCN: 14Z317 | Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		856,425		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	05/07/2015	25,934		0	3.01
3.02		09/22/2015	276,400		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)		302,334		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,158,759		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		34,624		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,193,383		0	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: 141317 | Component CCN: 145979 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Skilled Nursing Facility | 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		175,264		97	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)		175,264		97	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		7	6.02
7.00	Total Medicare program liability (see instructions)		175,264		90	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: 141317	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/23/2016 6:02 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	763	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,056	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	351	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,305	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	147,259,239	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	2,514,515	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	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)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141317 | Component CCN: 14Z317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-2 | Date/Time Prepared: 2/23/2016 6:02 pm

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	976,176	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	244,082	0	3.00
4.00	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.00
5.00	Program days	454	0	5.00
6.00	Interns and residents not in approved teaching program (see instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,220,258	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,220,258	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applicable to physician professional services)	0	0	11.00
12.00	Subtotal (line 10 minus line 11)	1,220,258	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,520	0	13.00
14.00	80% of Part B costs (line 12 x 80%)		0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,217,738	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT	0		16.55
17.00	Allowable bad debts (see instructions)	0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	1,217,738	0	19.00
19.01	Sequestration adjustment (see instructions)	24,355	0	19.01
20.00	Interim payments	1,158,759	0	20.00
21.00	Tentative settlement (for contractor use only)	0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	34,624	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141317	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part V Date/Time Prepared: 2/23/2016 6:02 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	6,171,175	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)	6,171,175	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	6,232,887	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)	6,232,887	19.00
20.00	Deductibles (exclude professional component)	353,192	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	5,879,695	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	5,879,695	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	16,336	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	10,618	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	16,336	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	5,890,313	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)	5,890,313	30.00
30.01	Sequestration adjustment (see instructions)	117,806	30.01
31.00	Interim payments	5,157,072	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)	615,435	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141317 Component CCN: 145979	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part VI Date/Time Prepared: 2/23/2016 6:02 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	199,400	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)	199,400	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	0	6.00
7.00	Coinsurance	20,559	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)	178,841	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	178,841	15.00
15.01	Sequestration adjustment (see instructions)	3,577	15.01
16.00	Interim payments	175,264	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

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet E-3 Part VII | Date/Time Prepared: 2/23/2016 6:02 pm

Title XIX | Hospital | Cost

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141317 Component CCN: 145979	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part VII Date/Time Prepared: 2/23/2016 6:02 pm
	Title XIX	Skilled Nursing Facility	PPS

		Inpatient	Outpatient	
		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
	CUSTOMARY CHARGES			
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G | Date/Time Prepared: 2/23/2016 6:02 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	0	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	17,341,202	0	0	0	4.00
5.00	Other receivable	499,522	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	622,438	0	0	0	7.00
8.00	Prepaid expenses	792,452	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)	19,255,614	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	29,776,361	0	0	0	15.00
16.00	Accumulated depreciation	0	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)	29,776,361	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	8,098,255	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	381,651	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	8,479,906	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	57,511,881	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,938,213	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,100,028	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,721,334	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	1,388,856	0	0	0	43.00
44.00	Other current liabilities	8,913,236	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	20,061,667	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	13,973,179	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	13,973,179	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	34,034,846	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	23,477,035				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	23,477,035	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	57,511,881	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-1 | Date/Time Prepared: 2/23/2016 6:02 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		25,207,671		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-1,730,635				2.00
3.00	Total (sum of line 1 and line 2)		23,477,036		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	ROUNDING	0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		23,477,036		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	ROUNDING	1		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		1		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		23,477,035		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	ROUNDING		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	ROUNDING		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: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/23/2016 6:02 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	9,312,403		9,312,403	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	172,267		172,267	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	3,500,997		3,500,997	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	12,985,667		12,985,667	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	151,049		151,049	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)	151,049		151,049	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	13,136,716		13,136,716	17.00
18.00	Ancillary services	31,231,597	86,123,804	117,355,401	18.00
19.00	Outpatient services	701,164	14,755,564	15,456,728	19.00
20.00	RURAL HEALTH CLINIC	8,861	11,217,506	11,226,367	20.00
20.01	RURAL HEALTH CLINIC (RHC)	0	0	0	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	5,846,417	5,846,417	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER NRCC	255,342	10,959,467	11,214,809	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	45,333,680	128,902,758	174,236,438	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		79,866,421		29.00
30.00	BAD DEBTS	3,086,709			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)		3,086,709		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		82,953,130		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141317 | Period: From 10/01/2014 To 09/30/2015 | Worksheet G-3 | Date/Time Prepared: 2/23/2016 6:02 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	174,236,438	1.00
2.00	Less contractual allowances and discounts on patients' accounts	95,768,865	2.00
3.00	Net patient revenues (line 1 minus line 2)	78,467,573	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	82,953,130	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-4,485,557	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	513,287	6.00
7.00	Income from investments	185,387	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	2,129,676	24.00
24.01	GRANT INCOME	203,251	24.01
24.02	REALIZED GAIN	156,124	24.02
24.03		0	24.03
24.04		0	24.04
25.00	Total other income (sum of lines 6-24)	3,187,725	25.00
26.00	Total (line 5 plus line 25)	-1,297,832	26.00
27.00	UNREALIZED LOSS	432,802	27.00
27.01	ROUNDING	1	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	432,803	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-1,730,635	29.00

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

Provider CCN: 141317 | Component CCN: 143408 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/23/2016 6:02 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	3,357,482	0	3,357,482	0	3,357,482	1.00
2.00	Physician Assistant	211,995	0	211,995	0	211,995	2.00
3.00	Nurse Practitioner	930,516	0	930,516	0	930,516	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	750,554	0	750,554	0	750,554	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)	5,250,547	0	5,250,547	0	5,250,547	10.00
11.00	Physician Services Under Agreement	240,000	0	240,000	0	240,000	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)	240,000	0	240,000	0	240,000	14.00
15.00	Medical Supplies	0	673,918	673,918	0	673,918	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	673,918	673,918	0	673,918	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	5,490,547	673,918	6,164,465	0	6,164,465	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	988,801	2,362,316	3,351,117	399,383	3,750,500	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	988,801	2,362,316	3,351,117	399,383	3,750,500	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	6,479,348	3,036,234	9,515,582	399,383	9,914,965	32.00

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

Provider CCN: 141317 | Component CCN: 143408 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/23/2016 6:02 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	3,357,482		1.00
2.00	Physician Assistant	0	211,995		2.00
3.00	Nurse Practitioner	0	930,516		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	750,554		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	5,250,547		10.00
11.00	Physician Services Under Agreement	0	240,000		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	240,000		14.00
15.00	Medical Supplies	0	673,918		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	673,918		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	6,164,465		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-402,868	3,347,632		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-402,868	3,347,632		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-402,868	9,512,097		32.00

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

Provider CCN: 141317 | Component CCN: 148546 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/23/2016 6:02 pm

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	48,647	0	48,647	-3,239	45,408	1.00
2.00	Physician Assistant	16,019	0	16,019	0	16,019	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	12,872	0	12,872	0	12,872	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)	77,538	0	77,538	-3,239	74,299	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	20,376	20,376	0	20,376	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	20,376	20,376	0	20,376	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	77,538	20,376	97,914	-3,239	94,675	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	3,669	3,669	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	0	24,587	24,587	0	24,587	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	24,587	24,587	0	24,587	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	77,538	44,963	122,501	-3,239	119,262	32.00

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

Provider CCN: 141317 | Component CCN: 148546 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-1 | Date/Time Prepared: 2/23/2016 6:02 pm

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	45,408		1.00
2.00	Physician Assistant	0	16,019		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	12,872		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	74,299		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	20,376		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	20,376		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	94,675		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	-99	3,570		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	24,587		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	24,587		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	119,262		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141317 | Component CCN: 143408 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-2 | Date/Time Prepared: 2/23/2016 6:02 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	5.37	22,771	4,200	22,554		1.00
2.00	Physician Assistant	0.89	2,094	2,100	1,869		2.00
3.00	Nurse Practitioner	4.64	11,820	2,100	9,744		3.00
4.00	Subtotal (sum of lines 1 through 3)	10.90	36,685		34,167	36,685	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)	10.90	36,685			36,685	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)	6,164,465	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)	6,164,465	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)	3,347,632	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	2,968,186	15.00
16.00	Total overhead (sum of lines 14 and 15)	6,315,818	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	6,315,818	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	6,315,818	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	12,480,283	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141317 | Component CCN: 148546 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-2 | Date/Time Prepared: 2/23/2016 6:02 pm

Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.15	646	4,200	630		1.00
2.00	Physician Assistant	0.15	1,160	2,100	315		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.30	1,806		945	1,806	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	0.30	1,806			1,806	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)					94,675	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)					94,675	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)					24,587	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					60,833	15.00
16.00	Total overhead (sum of lines 14 and 15)					85,420	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					85,420	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					85,420	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					180,095	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141317 Component CCN: 143408 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-3 Date/Time Prepared: 2/23/2016 6:02 pm

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		12,480,283	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		215,286	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		12,264,997	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		36,685	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)		36,685	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		334.33	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	334.33	334.33	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	7,068	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	2,363,044	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) *		2,363,044	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,297,754	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		18,728	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		34,101	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.)		1,800,106	16.04
16.05	Total program cost (see instructions)		1,834,207	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		78,810	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		240,043	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,834,207	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		121,237	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,955,444	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)		1,955,444	26.00
26.01	Sequestration adjustment (see instructions)		39,109	26.01
27.00	Interim payments		1,397,643	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)		518,692	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141317 Component CCN: 148546	Period: From 10/01/2014 To 09/30/2015	Worksheet M-3 Date/Time Prepared: 2/23/2016 6:02 pm
	Title XVIII	Rural Health Clinic (RHC) II	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)		180,095	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		180,095	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		1,806	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)		1,806	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		99.72	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	99.72	99.72	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	139	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	13,861	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) *		13,861	16.00
16.01	Total program charges (see instructions)(from contractor's records)		25,640	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		10,674	16.04
16.05	Total program cost (see instructions)		10,674	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		519	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,024	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		10,674	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		10,674	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)		10,674	26.00
26.01	Sequestration adjustment (see instructions)		213	26.01
27.00	Interim payments		8,316	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)		2,145	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141317 | Component CCN: 143408 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-4 | Date/Time Prepared: 2/23/2016 6:02 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	5,250,547	5,250,547	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.001932	0.003668	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	10,144	19,259	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	50,176	26,759	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	60,320	46,018	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	6,164,465	6,164,465	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	6,315,818	6,315,818	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.009785	0.007465	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	61,800	47,148	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	122,120	93,166	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	572	1,085	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	213.50	85.87	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	302	661	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	64,477	56,760	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)		215,286	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)		121,237	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141317 | Component CCN: 148546 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-4 | Date/Time Prepared: 2/23/2016 6:02 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	74,299	74,299	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	0	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	0	0	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	94,675	94,675	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	85,420	85,420	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000000	0.000000	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	0	0	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	0	0	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	0	0	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	0.00	0.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	0	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	0	0	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)		0	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)		0	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 141317 Component CCN: 143408 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-5 | Date/Time Prepared: 2/23/2016 6:02 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		1,053,961	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		05/07/2015	197,246	3.01
3.02		09/22/2015	146,436	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)		343,682	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,397,643	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		518,692	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,916,335	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 HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

Provider CCN: 141317 Component CCN: 148546 | Period: From 10/01/2014 To 09/30/2015 | Worksheet M-5 | Date/Time Prepared: 2/23/2016 6:02 pm

Rural Health Clinic (RHC) II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		8,316	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		8,316	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		2,145	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		10,461	7.00

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