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: 141320	Period: From 01/01/2015 To 12/31/2015	Worksheet S Parts I-III Date/Time Prepared: 5/18/2016 12:53 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/18/2016 Time: 12:53 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 PARIS COMMUNITY HOSPITAL (141320) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	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	964,961	-84,429	1	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	282,744	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		57,140		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-2,021		0	10.01
10.02	RURAL HEALTH CLINIC III	0		482		0	10.02
200.00	Total	0	1,247,705	-28,828	1	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 12:34 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 721 EAST COURT STREET	PO Box:			1.00
2.00	City: PARIS	State: IL	Zip Code: 61944-	County: EDGAR	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	PARIS COMMUNITY HOSPITAL	141320	14999	1	06/30/2002	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	PARIS COMMUNITY HOSPITAL	14Z320	14999		06/30/2002	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FMC	143987	14999		09/24/1994	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	HATCH	143989	14999		01/01/1995	N	O	N	15.01
15.02	Hospital-Based Health Clinic - RHC III	FMC	143431	14999		02/16/1997	N	O	N	15.02
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)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2016 12:34 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.	1		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.	1		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.				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: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/18/2016 12:34 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	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/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)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 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.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

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

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	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: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/18/2016 12:34 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)						1	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)	01/01/2015	12/31/2015	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: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/18/2016 12:34 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	12/31/2015	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	05/10/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/18/2016 12:34 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.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JAKE	CARNAZZO	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923476	JCARNAZZO@ALLIANTMANAGEMENT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/18/2016 12:34 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)	05/10/2016			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/18/2016 12:34 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	25	9,125	34,320.00	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)		25	9,125	34,320.00	0	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)		25	9,125	34,320.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88.02				0	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/18/2016 12:34 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)	957	184	1,540			1.00
2.00	HMO and other (see instructions)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	584	0	584			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	2,481			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,541	184	4,605			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)	1,541	184	4,605	0.00	223.73	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	8,265	0	36,409	0.00	57.09	26.00
26.01	RURAL HEALTH CLINIC II	302	0	1,572	0.00	3.07	26.01
26.02	RURAL HEALTH CLINIC III	22	0	142	0.00	0.30	26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	284.19	27.00
28.00	Observation Bed Days		0	202			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/18/2016 12:34 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	316	68	530	1.00
2.00	HMO and other (see instructions)			0	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	316	68	530	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.02	RURAL HEALTH CLINIC III	0.00					26.02
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV | Date/Time Prepared: 5/18/2016 12:34 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	432,640	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	3,834,106	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	112,063	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	82,317	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	81,636	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	1,256,598	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	33,184	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	10,506	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	5,843,050	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

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

Provider CCN: 141320 Component CCN: 143987 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-8 Date/Time Prepared: 5/18/2016 12:34 pm

			Rural Health Clinic (RHC) I	Cost
			1.00	
	Clinic Address and Identification			
1.00	Street		727 EAST COURT STREET	1.00
		City	State	ZIP Code
		1.00	2.00	3.00
2.00	City, State, ZIP Code, County	PARIS	IL	61944 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
9.01			0	9.01
9.02			0	9.02
9.03			0	9.03
9.04			0	9.04
9.05			0	9.05
9.06			0	9.06
9.07			0	9.07
9.08			0	9.08
9.09			0	9.09
9.10			0	9.10
			1.00	2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)		N	0 10.00

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

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

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

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

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

Provider CCN: 141320
Component CCN: 143987

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-8

Date/Time Prepared:
5/18/2016 12:34 pm

Rural Health Clinic (RHC) I

Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		EDGAR				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:00	19:00	08:00	19:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	19:00	08:00	11:30		11.00

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

Provider CCN: 141320 Component CCN: 143989 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-8 Date/Time Prepared: 5/18/2016 12:34 pm

			Rural Health Clinic (RHC) II	Cost	
			1.00		
	Clinic Address and Identification				
1.00	Street		144 ILLINOIS		1.00
		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	CHRISMAN	IL	61924	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
9.01			0		9.01
9.02			0		9.02
9.03			0		9.03
9.04			0		9.04
9.05			0		9.05
9.06			0		9.06
9.07			0		9.07
9.08			0		9.08
9.09			0		9.09
9.10			0		9.10
			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	12:00	13:30	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

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

Provider CCN: 141320
Component CCN: 143989

Period:
From 01/01/2015
To 12/31/2015

Worksheet S-8

Date/Time Prepared:
5/18/2016 12:34 pm

Rural Health Clinic (RHC) II

Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		EDGAR				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	19:30			08:00	12:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	12:00				11.00

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

Provider CCN: 141320 Component CCN: 143431 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-8 | Date/Time Prepared: 5/18/2016 12:34 pm

		Rural Health Clinic (RHC) III	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	104 BUENA VISTA	1.00
		City / State / ZIP Code	
		1.00 / 2.00 / 3.00	
2.00	City, State, ZIP Code, County	KANSAS IL 61933	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
9.01		0	9.01
9.02		0	9.02
9.03		0	9.03
9.04		0	9.04
9.05		0	9.05
9.06		0	9.06
9.07		0	9.07
9.08		0	9.08
9.09		0	9.09
9.10		0	9.10
		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 from	Sunday to	Monday from	Monday to	Tuesday from
		1.00	2.00	3.00	4.00	5.00
	Facility hours of operations (1)					
11.00	Clinic			08:30	12:00	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

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

Provider CCN: 141320
Component CCN: 143431

Period: From 01/01/2015 To 12/31/2015

Worksheet S-8
Date/Time Prepared: 5/18/2016 12:34 pm

Rural Health Clinic (RHC) III

Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		EDGAR				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		08:30	12:00	13:30	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						11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 5/18/2016 12:34 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)	0.411209	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,330,944	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	20,688,485	6.00
7.00	Medicaid cost (line 1 times line 6)	8,507,291	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)	4,176,347	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	4,176,347	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	360,287	301,581	661,868	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	148,153	124,013	272,166	21.00
22.00	Partial payment by patients approved for charity care	8,715	391	9,106	22.00
23.00	Cost of charity care (line 21 minus line 22)	139,438	123,622	263,060	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)	4,030,156	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	504,178	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,525,978	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,449,914	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,712,974	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	5,889,321	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/18/2016 12:34 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	NEW CAP REL COSTS-BLDG & FIXT		1,049,759	1,049,759	184,069	1,233,828	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		1,277,357	1,277,357	175,085	1,452,442	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	84,668	4,630,076	4,714,744	-300,169	4,414,575	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	1,774,595	2,165,118	3,939,713	-240,726	3,698,987	5.01
5.02	00560	ADMITTING	518,261	337,950	856,211	-623	855,588	5.02
7.00	00700	OPERATION OF PLANT	400,226	720,156	1,120,382	-1,445	1,118,937	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	143,376	143,376	0	143,376	8.00
9.00	00900	HOUSEKEEPING	187,293	61,042	248,335	0	248,335	9.00
10.00	01000	DIETARY	390,201	220,068	610,269	-351,301	258,968	10.00
11.00	01100	CAFETERIA	0	0	0	351,301	351,301	11.00
13.00	01300	NURSING ADMINISTRATION	810,040	114,298	924,338	0	924,338	13.00
15.00	01500	PHARMACY	126,314	1,581,490	1,707,804	-1,551,035	156,769	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	443,171	73,646	516,817	0	516,817	16.00
17.00	01700	SOCIAL SERVICE	0	62,139	62,139	0	62,139	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,662,974	291,856	1,954,830	-24,592	1,930,238	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,194,515	2,787,815	3,982,330	-2,228,744	1,753,586	50.00
53.00	05300	ANESTHESIOLOGY	738,769	119,671	858,440	178,220	1,036,660	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,363,446	766,403	2,129,849	90,359	2,220,208	54.00
60.00	06000	LABORATORY	728,680	935,243	1,663,923	-27	1,663,896	60.00
65.00	06500	RESPIRATORY THERAPY	314,705	82,364	397,069	-38,355	358,714	65.00
66.00	06600	PHYSICAL THERAPY	891,820	139,280	1,031,100	0	1,031,100	66.00
69.00	06900	ELECTROCARDIOLOGY	0	47,046	47,046	56,041	103,087	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,056	2,056	0	2,056	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	904,381	904,381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	1,458,179	1,458,179	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,582,146	1,582,146	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,566,682	1,561,855	5,128,537	-27,170	5,101,367	88.00
88.01	08801	RURAL HEALTH CLINIC II	169,090	100,783	269,873	-30,966	238,907	88.01
88.02	08802	RURAL HEALTH CLINIC III	21,894	11,265	33,159	-5,879	27,280	88.02
90.00	09000	CLINIC	92,343	49,940	142,283	-17,645	124,638	90.00
90.01	04951	CHEMO/PAIN	817,393	216,310	1,033,703	0	1,033,703	90.01
90.02	09002	SENIOR CARE	553	427,061	427,614	-25,200	402,414	90.02
90.03	09003	SLEEP LAB	62,601	57,321	119,922	-135	119,787	90.03
91.00	09100	EMERGENCY	1,046,869	1,942,983	2,989,852	0	2,989,852	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		125,833	125,833	-125,833	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,407,103	22,101,560	39,508,663	9,936	39,518,599	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,075,500	617,923	2,693,423	-9,936	2,683,487	192.00
192.01	19202	OCCUPATIONAL MEDICINE	750	1,143	1,893	0	1,893	192.01
200.00		TOTAL (SUM OF LINES 118-199)	19,483,353	22,720,626	42,203,979	0	42,203,979	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/18/2016 12:34 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	-74,142	1,159,686		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-174,858	1,277,584		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	4,414,575		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	-347,923	3,351,064		5.01
5.02	00560	ADMITTING	0	855,588		5.02
7.00	00700	OPERATION OF PLANT	0	1,118,937		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	143,376		8.00
9.00	00900	HOUSEKEEPING	0	248,335		9.00
10.00	01000	DIETARY	0	258,968		10.00
11.00	01100	CAFETERIA	-92,948	258,353		11.00
13.00	01300	NURSING ADMINISTRATION	0	924,338		13.00
15.00	01500	PHARMACY	0	156,769		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-6,103	510,714		16.00
17.00	01700	SOCIAL SERVICE	0	62,139		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-293,966	1,636,272		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-80,486	1,673,100		50.00
53.00	05300	ANESTHESIOLOGY	-980,713	55,947		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-678,726	1,541,482		54.00
60.00	06000	LABORATORY	0	1,663,896		60.00
65.00	06500	RESPIRATORY THERAPY	0	358,714		65.00
66.00	06600	PHYSICAL THERAPY	0	1,031,100		66.00
69.00	06900	ELECTROCARDIOLOGY	-46,812	56,275		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-1,827	229		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	904,381		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,458,179		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-30,363	1,551,783		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-184,624	4,916,743		88.00
88.01	08801	RURAL HEALTH CLINIC II	-5,762	233,145		88.01
88.02	08802	RURAL HEALTH CLINIC III	-200	27,080		88.02
90.00	09000	CLINIC	-18,382	106,256		90.00
90.01	04951	CHEMO/PAIN	-308,815	724,888		90.01
90.02	09002	SENIOR CARE	-3,600	398,814		90.02
90.03	09003	SLEEP LAB	-30,912	88,875		90.03
91.00	09100	EMERGENCY	-1,406,588	1,583,264		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,767,750	34,750,849		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	-10,000	2,673,487		192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	1,893		192.01
200.00		TOTAL (SUM OF LINES 118-199)	-4,777,750	37,426,229		200.00

RECLASSIFICATIONS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/18/2016 12:34 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RENTAL EXPENSE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	175,085	1.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
	TOTALS		0	175,085	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	224,619	126,682	1.00
	TOTALS		224,619	126,682	
	C - EKG				
1.00	ELECTROCARDIOLOGY	69.00	38,396	0	1.00
2.00		0.00	0	0	2.00
	TOTALS		38,396	0	
	D - PROPERTY INSURANCE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	58,236	1.00
	TOTALS		0	58,236	
	E - OXYGEN/PATIENT SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	175,654	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	175,654	
	F - DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,582,146	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	1,582,146	
	H - TELEPHONE				
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	32,902	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
	TOTALS		0	32,902	
	I - STRESS TEST				
1.00	ELECTROCARDIOLOGY	69.00	11,452	6,193	1.00
	TOTALS		11,452	6,193	
	J - MED SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	728,727	1.00
2.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	1,458,179	2.00
	TOTALS		0	2,186,906	
	K - INTEREST EXPENSE				
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	125,833	1.00
	TOTALS		0	125,833	
	L - ANESTHESIA BENEFITS				
1.00	ANESTHESIOLOGY	53.00	0	178,699	1.00
	TOTALS		0	178,699	
	M - RADIOLOGY BENEFITS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	117,967	1.00
	TOTALS		0	117,967	
	N - WOUND CARE BENEFITS				
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,503	1.00
	TOTALS		0	3,503	
500.00	Grand Total: Increases		274,467	4,769,806	500.00

RECLASSIFICATIONS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/18/2016 12:34 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENTAL EXPENSE						
1.00		0.00	0	0	10		1.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	47,227	0		3.00
4.00	ADMITTING	5.02	0	623	0		4.00
5.00	OPERATION OF PLANT	7.00	0	1,445	0		5.00
9.00	ADULTS & PEDIATRICS	30.00	0	5,107	0		9.00
10.00	OPERATING ROOM	50.00	0	41,838	0		10.00
11.00	ANESTHESIOLOGY	53.00	0	479	0		11.00
13.00	LABORATORY	60.00	0	27	0		13.00
14.00	RESPIRATORY THERAPY	65.00	0	11,955	0		14.00
15.00	SENIOR CARE	90.02	0	25,200	0		15.00
17.00	RURAL HEALTH CLINIC	88.00	0	8,382	0		17.00
18.00	RURAL HEALTH CLINIC II	88.01	0	19,039	0		18.00
19.00	RURAL HEALTH CLINIC III	88.02	0	5,178	0		19.00
20.00	SLEEP LAB	90.03	0	135	0		20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	8,450	0		21.00
	TOTALS		0	175,085			
	B - CAFETERIA						
1.00	DIETARY	10.00	224,619	126,682	0		1.00
	TOTALS		224,619	126,682			
	C - EKG						
1.00	ADULTS & PEDIATRICS	30.00	19,485	0	0		1.00
2.00	RESPIRATORY THERAPY	65.00	18,911	0	0		2.00
	TOTALS		38,396	0			
	D - PROPERTY INSURANCE						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	58,236	9		1.00
	TOTALS		0	58,236			
	E - OXYGEN/PATIENT SUPPLIES						
1.00	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	168,165	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	7,489	0		2.00
	TOTALS		0	175,654			
	F - DRUGS						
1.00	PHARMACY	15.00	0	1,551,035	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	31,111	0		2.00
	TOTALS		0	1,582,146			
	H - TELEPHONE						
1.00		0.00	0	0	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	18,788	0		2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	11,927	0		3.00
4.00	RURAL HEALTH CLINIC III	88.02	0	701	0		4.00
5.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1,486	0		5.00
	TOTALS		0	32,902			
	I - STRESS TEST						
1.00	CLINIC	90.00	11,452	6,193	0		1.00
	TOTALS		11,452	6,193			
	J - MED SUPPLIES						
1.00	OPERATING ROOM	50.00	0	2,186,906	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	2,186,906			
	K - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	125,833	9		1.00
	TOTALS		0	125,833			
	L - ANESTHESIA BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	178,699	0		1.00
	TOTALS		0	178,699			
	M - RADIOLOGY BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	117,967	0		1.00
	TOTALS		0	117,967			
	N - WOUND CARE BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,503	0		1.00
	TOTALS		0	3,503			
500.00	Grand Total: Decreases		274,467	4,769,806			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/18/2016 12:34 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	41,266	0	0	0	0	1.00
2.00	Land Improvements	1,949,572	0	0	0	0	2.00
3.00	Buildings and Fixtures	22,852,793	853,290	0	853,290	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	14,796,967	850,629	0	850,629	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	39,640,598	1,703,919	0	1,703,919	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	39,640,598	1,703,919	0	1,703,919	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	41,266	0	1.00
2.00	Land Improvements	1,949,572	0	2.00
3.00	Buildings and Fixtures	23,706,083	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	15,647,596	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	41,344,517	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	41,344,517	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/18/2016 12:34 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	NEW CAP REL COSTS-BLDG & FIXT	1,049,759	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,277,357	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,327,116	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	NEW CAP REL COSTS-BLDG & FIXT	0	1,049,759		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	1,277,357		2.00
3.00	Total (sum of lines 1-2)	0	2,327,116		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/18/2016 12:34 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	NEW CAP REL COSTS-BLDG & FIXT	1,049,759	0	1,049,759	0.451099	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	1,277,357	0	1,277,357	0.548901	0	2.00
3.00	Total (sum of lines 1-2)	2,327,116	0	2,327,116	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1,159,686	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,277,357	175,085	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,437,043	175,085	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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	1,159,686	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	-174,858	0	0	0	1,277,584	2.00
3.00	Total (sum of lines 1-2)	-174,858	0	0	0	2,437,270	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/18/2016 12:34 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 - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-58,229	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	NEW 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)	B	-31,720	OTHER ADMINISTRATIVE AND GENERAL	5.01	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	-2,198,923			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-92,948	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others	B	-15,913	NEW CAP REL COSTS-BLDG & FIXT	1.00	9	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-30,363	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-6,103	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	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 - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW 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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/18/2016 12:34 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	
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	PHYSICIAN RECRUTING	A	-28,591	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	33.00
34.00	ADVERTISING	A	-71,749	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	34.00
35.00			0		0.00	0	35.00
36.00	ADVERTISING	A	-60,698	RURAL HEALTH CLINIC	88.00	0	36.00
37.00	ADVERTISING	A	-5,762	RURAL HEALTH CLINIC II	88.01	0	37.00
38.00	ADVERTISING	A	-200	RURAL HEALTH CLINIC III	88.02	0	38.00
39.00			0		0.00	0	39.00
40.00	ANESTHESIA	A	-769,015	ANESTHESIOLOGY	53.00	0	40.00
41.00	ANESTHESIA OTHER	A	-211,698	ANESTHESIOLOGY	53.00	0	41.00
42.00	OTHER REVENUE	B	-142,258	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	42.00
43.00	CPR	B	-26,457	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	43.00
44.00	IHA	A	-14,083	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	44.00
45.00	FMC OTHER REVENUE	B	-123,926	RURAL HEALTH CLINIC	88.00	0	45.00
45.01			0		0.00	0	45.01
45.02			0		0.00	0	45.02
45.03	FMC OTHER REVENUE	B	-10,000	PHYSICIANS' PRIVATE OFFICES	192.00	0	45.03
45.04	AHA	A	-2,918	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.04
45.05			0		0.00	0	45.05
45.06	NRHA	A	-101	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.06
45.07	RADIOLOGY	A	-546,277	RADIOLOGY-DIAGNOSTIC	54.00	0	45.07
45.08	RADIOLOGY OTHER	A	-132,449	RADIOLOGY-DIAGNOSTIC	54.00	0	45.08
45.09	WOUND CARE	A	-14,481	CHEMO/PAIN	90.01	0	45.09
45.10	WOUND CARE OTHER	A	-4,305	CHEMO/PAIN	90.01	0	45.10
45.11			0		0.00	0	45.11
45.12	MCHC DUES	A	-125	OTHER ADMINISTRATIVE AND GENERAL	5.01	0	45.12
45.13	ADVERTISING	A	-3,600	SENIOR CARE	90.02	0	45.13
45.14			0		0.00	0	45.14
45.15	MEANINGFUL USE ACCELERATED PAYMENT	A	-174,858	NEW CAP REL COSTS-MVBLE EQUIP	2.00	11	45.15
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-4,777,750				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: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/18/2016 12:34 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	5.01	OTHER ADMINISTRATIVE AND GENERAL	29,921	29,921	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	293,966	293,966	0	0	0	2.00
3.00	50.00	OPERATING ROOM	80,486	80,486	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	56,812	46,812	10,000	0	0	6.00
7.00	70.00	ELECTROENCEPHALOGRAPHY	1,827	1,827	0	0	0	7.00
8.00	90.00	CLINIC	27,382	18,382	9,000	0	0	8.00
9.00	90.01	CHEMO/PAIN	318,029	290,029	28,000	0	0	9.00
10.00	90.02	SENIOR CARE	21,500	0	21,500	0	0	10.00
11.00	90.03	SLEEP LAB	30,912	30,912	0	0	0	11.00
12.00	91.00	EMERGENCY	1,790,873	1,406,588	384,285	0	0	12.00
200.00			2,651,708	2,198,923	452,785		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	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	4.00
5.00	60.00	LABORATORY	0	0	0	0	0	5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	6.00
7.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	7.00
8.00	90.00	CLINIC	0	0	0	0	0	8.00
9.00	90.01	CHEMO/PAIN	0	0	0	0	0	9.00
10.00	90.02	SENIOR CARE	0	0	0	0	0	10.00
11.00	90.03	SLEEP LAB	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	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	5.01	OTHER ADMINISTRATIVE AND GENERAL	0	0	0	29,921		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	293,966		2.00
3.00	50.00	OPERATING ROOM	0	0	0	80,486		3.00
4.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0		4.00
5.00	60.00	LABORATORY	0	0	0	0		5.00
6.00	69.00	ELECTROCARDIOLOGY	0	0	0	46,812		6.00
7.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	1,827		7.00
8.00	90.00	CLINIC	0	0	0	18,382		8.00
9.00	90.01	CHEMO/PAIN	0	0	0	290,029		9.00
10.00	90.02	SENIOR CARE	0	0	0	0		10.00
11.00	90.03	SLEEP LAB	0	0	0	30,912		11.00
12.00	91.00	EMERGENCY	0	0	0	1,406,588		12.00
200.00			0	0	0	2,198,923		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I Date/Time Prepared: 5/18/2016 12:34 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	1,159,686	1,159,686				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,277,584		1,277,584			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,414,575	8,715	9,601	4,432,891		4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	3,351,064	192,091	211,622	432,891	4,187,668	5.01
5.02	00560	ADMITTING	855,588	30,929	34,074	126,424	1,047,015	5.02
7.00	00700	OPERATION OF PLANT	1,118,937	111,506	122,842	97,630	1,450,915	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	143,376	9,128	10,056	0	162,560	8.00
9.00	00900	HOUSEKEEPING	248,335	6,421	7,074	45,688	307,518	9.00
10.00	01000	DIETARY	258,968	28,842	31,775	40,392	359,977	10.00
11.00	01100	CAFETERIA	258,353	13,124	14,458	54,793	340,728	11.00
13.00	01300	NURSING ADMINISTRATION	924,338	12,973	14,292	197,600	1,149,203	13.00
15.00	01500	PHARMACY	156,769	8,188	9,021	30,813	204,791	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	510,714	20,974	23,106	108,106	662,900	16.00
17.00	01700	SOCIAL SERVICE	62,139	1,467	1,616	0	65,222	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,636,272	131,671	145,057	400,909	2,313,909	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,673,100	95,468	105,173	291,388	2,165,129	50.00
53.00	05300	ANESTHESIOLOGY	55,947	1,119	1,232	0	58,298	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,541,482	69,239	76,278	213,630	1,900,629	54.00
60.00	06000	LABORATORY	1,663,896	28,852	31,785	177,753	1,902,286	60.00
65.00	06500	RESPIRATORY THERAPY	358,714	3,582	3,946	72,155	438,397	65.00
66.00	06600	PHYSICAL THERAPY	1,031,100	41,393	45,601	217,549	1,335,643	66.00
69.00	06900	ELECTROCARDIOLOGY	56,275	4,926	5,427	12,160	78,788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	229	2,896	3,190	0	6,315	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	904,381	0	0	0	904,381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,458,179	0	0	0	1,458,179	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,551,783	0	0	0	1,551,783	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,916,743	172,697	190,254	870,044	6,149,738	88.00
88.01	08801	RURAL HEALTH CLINIC II	233,145	14,102	15,535	41,247	304,029	88.01
88.02	08802	RURAL HEALTH CLINIC III	27,080	5,772	6,359	5,341	44,552	88.02
90.00	09000	CLINIC	106,256	5,782	6,369	19,732	138,139	90.00
90.01	04951	CHEMO/PAIN	724,888	11,620	12,801	199,393	948,702	90.01
90.02	09002	SENIOR CARE	398,814	15,042	16,571	135	430,562	90.02
90.03	09003	SLEEP LAB	88,875	1,222	1,346	15,271	106,714	90.03
91.00	09100	EMERGENCY	1,583,264	48,453	53,379	255,371	1,940,467	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	34,750,849	1,098,194	1,209,840	3,926,415	34,115,137	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,673,487	41,327	45,529	506,293	3,266,636	192.00
192.01	19202	OCCUPATIONAL MEDICINE	1,893	20,165	22,215	183	44,456	192.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	37,426,229	1,159,686	1,277,584	4,432,891	37,426,229	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/18/2016 12:34 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	4,187,668					5.01
5.02	00560	ADMITTING	131,911	1,178,926				5.02
7.00	00700	OPERATION OF PLANT	182,798	0	1,633,713			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,481	0	18,266	201,307		8.00
9.00	00900	HOUSEKEEPING	38,744	0	12,848	0	359,110	9.00
10.00	01000	DIETARY	45,353	0	57,714	0	12,933	10.00
11.00	01100	CAFETERIA	42,928	0	26,261	0	5,885	11.00
13.00	01300	NURSING ADMINISTRATION	144,786	0	25,960	0	5,817	13.00
15.00	01500	PHARMACY	25,801	0	16,385	0	3,672	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	83,517	0	41,969	0	9,404	16.00
17.00	01700	SOCIAL SERVICE	8,217	0	2,935	0	658	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	291,525	153,284	263,475	201,307	59,040	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	272,780	143,567	191,032	0	42,806	50.00
53.00	05300	ANESTHESIOLOGY	7,345	3,873	2,239	0	502	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	239,456	126,105	138,548	0	31,046	54.00
60.00	06000	LABORATORY	239,665	126,428	57,733	0	12,937	60.00
65.00	06500	RESPIRATORY THERAPY	55,233	29,152	7,167	0	1,606	65.00
66.00	06600	PHYSICAL THERAPY	168,275	88,656	82,828	0	18,560	66.00
69.00	06900	ELECTROCARDIOLOGY	9,926	5,217	9,857	0	2,209	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	796	405	5,794	0	1,298	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	113,941	60,179	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	183,713	97,030	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	195,506	103,259	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	774,800	0	345,568	0	77,434	88.00
88.01	08801	RURAL HEALTH CLINIC II	38,304	0	28,217	0	6,323	88.01
88.02	08802	RURAL HEALTH CLINIC III	5,613	0	11,550	0	2,588	88.02
90.00	09000	CLINIC	17,404	9,062	11,569	0	2,592	90.00
90.01	04951	CHEMO/PAIN	119,525	63,065	23,251	0	5,210	90.01
90.02	09002	SENIOR CARE	54,246	28,571	30,099	0	6,744	90.02
90.03	09003	SLEEP LAB	13,445	7,094	2,446	0	548	90.03
91.00	09100	EMERGENCY	244,476	133,979	96,955	0	21,726	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,770,510	1,178,926	1,510,666	201,307	331,538	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	411,557	0	82,696	0	18,530	192.00
192.01	19202	OCCUPATIONAL MEDICINE	5,601	0	40,351	0	9,042	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	4,187,668	1,178,926	1,633,713	201,307	359,110	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/18/2016 12:34 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	475,977					10.00
11.00	01100	CAFETERIA	0	415,802				11.00
13.00	01300	NURSING ADMINISTRATION	0	22,603	1,348,369			13.00
15.00	01500	PHARMACY	0	3,525	0	254,174		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,366	0	0	810,156	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	475,977	45,858	458,314	2	25,161	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	33,331	382,635	182	102,909	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	4	16,128	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	24,436	0	231	212,448	54.00
60.00	06000	LABORATORY	0	20,332	0	1	135,131	60.00
65.00	06500	RESPIRATORY THERAPY	0	8,254	0	255	5,307	65.00
66.00	06600	PHYSICAL THERAPY	0	24,884	0	166	72,831	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,391	0	0	12,596	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	111	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	73,787	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	204,552	73,556	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	99,521	0	45,079	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	4,718	0	2,911	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	611	0	12	0	88.02
90.00	09000	CLINIC	0	2,257	0	27	1,962	90.00
90.01	04951	CHEMO/PAIN	0	22,808	178,555	391	12,786	90.01
90.02	09002	SENIOR CARE	0	15	183	0	4,768	90.02
90.03	09003	SLEEP LAB	0	1,747	0	0	4,080	90.03
91.00	09100	EMERGENCY	0	29,211	328,682	110	56,595	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	475,977	357,868	1,348,369	253,923	810,156	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	57,913	0	220	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	21	0	31	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	475,977	415,802	1,348,369	254,174	810,156	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/18/2016 12:34 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	77,032					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	77,032	4,364,884	0	4,364,884		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,334,371	0	3,334,371		50.00
53.00	05300	ANESTHESIOLOGY	0	88,389	0	88,389		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,672,899	0	2,672,899		54.00
60.00	06000	LABORATORY	0	2,494,513	0	2,494,513		60.00
65.00	06500	RESPIRATORY THERAPY	0	545,371	0	545,371		65.00
66.00	06600	PHYSICAL THERAPY	0	1,791,843	0	1,791,843		66.00
69.00	06900	ELECTROCARDIOLOGY	0	119,984	0	119,984		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	14,719	0	14,719		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,152,288	0	1,152,288		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	1,738,922	0	1,738,922		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,128,656	0	2,128,656		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	7,492,140	0	7,492,140		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	384,502	0	384,502		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	64,926	0	64,926		88.02
90.00	09000	CLINIC	0	183,012	0	183,012		90.00
90.01	04951	CHEMO/PAIN	0	1,374,293	0	1,374,293		90.01
90.02	09002	SENIOR CARE	0	555,188	0	555,188		90.02
90.03	09003	SLEEP LAB	0	136,074	0	136,074		90.03
91.00	09100	EMERGENCY	0	2,852,201	0	2,852,201		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	77,032	33,489,175	0	33,489,175		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,837,552	0	3,837,552		192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	99,502	0	99,502		192.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	77,032	37,426,229	0	37,426,229		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/18/2016 12:34 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	8,715	9,601	18,316	18,316	4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	0	192,091	211,622	403,713	1,789	5.01
5.02	00560	ADMITTING	0	30,929	34,074	65,003	522	5.02
7.00	00700	OPERATION OF PLANT	0	111,506	122,842	234,348	403	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,128	10,056	19,184	0	8.00
9.00	00900	HOUSEKEEPING	0	6,421	7,074	13,495	189	9.00
10.00	01000	DIETARY	0	28,842	31,775	60,617	167	10.00
11.00	01100	CAFETERIA	0	13,124	14,458	27,582	226	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,973	14,292	27,265	817	13.00
15.00	01500	PHARMACY	0	8,188	9,021	17,209	127	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	20,974	23,106	44,080	447	16.00
17.00	01700	SOCIAL SERVICE	0	1,467	1,616	3,083	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	131,671	145,057	276,728	1,657	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	95,468	105,173	200,641	1,204	50.00
53.00	05300	ANESTHESIOLOGY	0	1,119	1,232	2,351	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	69,239	76,278	145,517	883	54.00
60.00	06000	LABORATORY	0	28,852	31,785	60,637	735	60.00
65.00	06500	RESPIRATORY THERAPY	0	3,582	3,946	7,528	298	65.00
66.00	06600	PHYSICAL THERAPY	0	41,393	45,601	86,994	899	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,926	5,427	10,353	50	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,896	3,190	6,086	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	172,697	190,254	362,951	3,593	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	14,102	15,535	29,637	170	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	5,772	6,359	12,131	22	88.02
90.00	09000	CLINIC	0	5,782	6,369	12,151	82	90.00
90.01	04951	CHEMO/PAIN	0	11,620	12,801	24,421	824	90.01
90.02	09002	SENIOR CARE	0	15,042	16,571	31,613	1	90.02
90.03	09003	SLEEP LAB	0	1,222	1,346	2,568	63	90.03
91.00	09100	EMERGENCY	0	48,453	53,379	101,832	1,055	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,098,194	1,209,840	2,308,034	16,223	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	41,327	45,529	86,856	2,092	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	20,165	22,215	42,380	1	192.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,159,686	1,277,584	2,437,270	18,316	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/18/2016 12:34 pm

		Cost Center Description	OTHER ADMINISTRATIVE AND GENERAL	ADMITTING	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.01	5.02	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	405,502					5.01
5.02	00560	ADMITTING	12,774	78,299				5.02
7.00	00700	OPERATION OF PLANT	17,701	0	252,452			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,983	0	2,823	23,990		8.00
9.00	00900	HOUSEKEEPING	3,752	0	1,985	0	19,421	9.00
10.00	01000	DIETARY	4,392	0	8,918	0	699	10.00
11.00	01100	CAFETERIA	4,157	0	4,058	0	318	11.00
13.00	01300	NURSING ADMINISTRATION	14,020	0	4,012	0	315	13.00
15.00	01500	PHARMACY	2,498	0	2,532	0	199	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,087	0	6,485	0	509	16.00
17.00	01700	SOCIAL SERVICE	796	0	453	0	36	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	28,230	10,188	40,714	23,990	3,193	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,415	9,534	29,519	0	2,315	50.00
53.00	05300	ANESTHESIOLOGY	711	257	346	0	27	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,188	8,375	21,409	0	1,679	54.00
60.00	06000	LABORATORY	23,208	8,396	8,921	0	700	60.00
65.00	06500	RESPIRATORY THERAPY	5,348	1,936	1,108	0	87	65.00
66.00	06600	PHYSICAL THERAPY	16,295	5,888	12,799	0	1,004	66.00
69.00	06900	ELECTROCARDIOLOGY	961	346	1,523	0	119	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	77	27	895	0	70	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	11,033	3,996	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	17,790	6,444	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	18,932	6,857	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	75,018	0	53,401	0	4,186	88.00
88.01	08801	RURAL HEALTH CLINIC II	3,709	0	4,360	0	342	88.01
88.02	08802	RURAL HEALTH CLINIC III	544	0	1,785	0	140	88.02
90.00	09000	CLINIC	1,685	602	1,788	0	140	90.00
90.01	04951	CHEMO/PAIN	11,574	4,188	3,593	0	282	90.01
90.02	09002	SENIOR CARE	5,253	1,897	4,651	0	365	90.02
90.03	09003	SLEEP LAB	1,302	471	378	0	30	90.03
91.00	09100	EMERGENCY	23,674	8,897	14,982	0	1,175	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	365,107	78,299	233,438	23,990	17,930	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	39,853	0	12,779	0	1,002	192.00
192.01	19202	OCCUPATIONAL MEDICINE	542	0	6,235	0	489	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	405,502	78,299	252,452	23,990	19,421	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/18/2016 12:34 pm

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	PHARMACY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	74,793					10.00
11.00	01100	CAFETERIA	0	36,341				11.00
13.00	01300	NURSING ADMINISTRATION	0	1,976	48,405			13.00
15.00	01500	PHARMACY	0	308	0	22,873		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,081	0	0	60,689	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	74,793	4,008	16,452	0	1,885	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,913	13,736	16	7,708	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,208	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,136	0	21	15,920	54.00
60.00	06000	LABORATORY	0	1,777	0	0	10,121	60.00
65.00	06500	RESPIRATORY THERAPY	0	721	0	23	398	65.00
66.00	06600	PHYSICAL THERAPY	0	2,175	0	15	5,455	66.00
69.00	06900	ELECTROCARDIOLOGY	0	122	0	0	943	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	8	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	5,527	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	18,408	5,509	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	8,697	0	4,057	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	412	0	262	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	53	0	1	0	88.02
90.00	09000	CLINIC	0	197	0	2	147	90.00
90.01	04951	CHEMO/PAIN	0	1,994	6,410	35	958	90.01
90.02	09002	SENIOR CARE	0	1	7	0	357	90.02
90.03	09003	SLEEP LAB	0	153	0	0	306	90.03
91.00	09100	EMERGENCY	0	2,553	11,800	10	4,239	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	74,793	31,277	48,405	22,850	60,689	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	5,062	0	20	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	2	0	3	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	74,793	36,341	48,405	22,873	60,689	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/18/2016 12:34 pm

		Cost Center Description	SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			17.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	4,368					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,368	486,206	0	486,206		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	294,001	0	294,001		50.00
53.00	05300	ANESTHESIOLOGY	0	4,900	0	4,900		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	219,128	0	219,128		54.00
60.00	06000	LABORATORY	0	114,495	0	114,495		60.00
65.00	06500	RESPIRATORY THERAPY	0	17,447	0	17,447		65.00
66.00	06600	PHYSICAL THERAPY	0	131,524	0	131,524		66.00
69.00	06900	ELECTROCARDIOLOGY	0	14,417	0	14,417		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,163	0	7,163		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,556	0	20,556		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	24,234	0	24,234		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	49,706	0	49,706		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	511,903	0	511,903		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	38,892	0	38,892		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	14,676	0	14,676		88.02
90.00	09000	CLINIC	0	16,794	0	16,794		90.00
90.01	04951	CHEMO/PAIN	0	54,279	0	54,279		90.01
90.02	09002	SENIOR CARE	0	44,145	0	44,145		90.02
90.03	09003	SLEEP LAB	0	5,271	0	5,271		90.03
91.00	09100	EMERGENCY	0	170,217	0	170,217		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	4,368	2,239,954	0	2,239,954		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	147,664	0	147,664		192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	49,652	0	49,652		192.01
200.00		Cross Foot Adjustments		0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	4,368	2,437,270	0	2,437,270		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/18/2016 12:34 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	OTHER ADMINISTRATIVE AND GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A.01	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	123,357					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		123,357				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	927	927	18,172,225			4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL	20,433	20,433	1,774,595	-4,187,668	33,238,561	5.01
5.02	00560	ADMITTING	3,290	3,290	518,261	0	1,047,015	5.02
7.00	00700	OPERATION OF PLANT	11,861	11,861	400,226	0	1,450,915	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	971	971	0	0	162,560	8.00
9.00	00900	HOUSEKEEPING	683	683	187,293	0	307,518	9.00
10.00	01000	DIETARY	3,068	3,068	165,583	0	359,977	10.00
11.00	01100	CAFETERIA	1,396	1,396	224,619	0	340,728	11.00
13.00	01300	NURSING ADMINISTRATION	1,380	1,380	810,040	0	1,149,203	13.00
15.00	01500	PHARMACY	871	871	126,314	0	204,791	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,231	2,231	443,171	0	662,900	16.00
17.00	01700	SOCIAL SERVICE	156	156	0	0	65,222	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,006	14,006	1,643,489	0	2,313,909	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,155	10,155	1,194,515	0	2,165,129	50.00
53.00	05300	ANESTHESIOLOGY	119	119	0	0	58,298	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,365	7,365	875,754	0	1,900,629	54.00
60.00	06000	LABORATORY	3,069	3,069	728,680	0	1,902,286	60.00
65.00	06500	RESPIRATORY THERAPY	381	381	295,794	0	438,397	65.00
66.00	06600	PHYSICAL THERAPY	4,403	4,403	891,820	0	1,335,643	66.00
69.00	06900	ELECTROCARDIOLOGY	524	524	49,848	0	78,788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	308	308	0	0	6,315	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	904,381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1,458,179	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,551,783	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	18,370	18,370	3,566,682	0	6,149,738	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,500	1,500	169,090	0	304,029	88.01
88.02	08802	RURAL HEALTH CLINIC III	614	614	21,894	0	44,552	88.02
90.00	09000	CLINIC	615	615	80,891	0	138,139	90.00
90.01	04951	CHEMO/PAIN	1,236	1,236	817,393	0	948,702	90.01
90.02	09002	SENIOR CARE	1,600	1,600	553	0	430,562	90.02
90.03	09003	SLEEP LAB	130	130	62,601	0	106,714	90.03
91.00	09100	EMERGENCY	5,154	5,154	1,046,869	0	1,940,467	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	116,816	116,816	16,095,975	-4,187,668	29,927,469	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,396	4,396	2,075,500	0	3,266,636	192.00
192.01	19202	OCCUPATIONAL MEDICINE	2,145	2,145	750	0	44,456	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,159,686	1,277,584	4,432,891		4,187,668	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.401055	10.356802	0.243938		0.125988	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			18,316		405,502	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001008		0.012200	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/18/2016 12:34 pm

		Cost Center Description	ADMITTING (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	
			5.02	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING	17,716,917					5.02
7.00	00700	OPERATION OF PLANT	0	86,846				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	971	100			8.00
9.00	00900	HOUSEKEEPING	0	683	0	85,192		9.00
10.00	01000	DIETARY	0	3,068	0	3,068	100	10.00
11.00	01100	CAFETERIA	0	1,396	0	1,396	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,380	0	1,380	0	13.00
15.00	01500	PHARMACY	0	871	0	871	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,231	0	2,231	0	16.00
17.00	01700	SOCIAL SERVICE	0	156	0	156	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,303,442	14,006	100	14,006	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,157,539	10,155	0	10,155	0	50.00
53.00	05300	ANESTHESIOLOGY	58,208	119	0	119	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,895,124	7,365	0	7,365	0	54.00
60.00	06000	LABORATORY	1,899,975	3,069	0	3,069	0	60.00
65.00	06500	RESPIRATORY THERAPY	438,101	381	0	381	0	65.00
66.00	06600	PHYSICAL THERAPY	1,332,335	4,403	0	4,403	0	66.00
69.00	06900	ELECTROCARDIOLOGY	78,397	524	0	524	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,086	308	0	308	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	904,381	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,458,179	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,551,783	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	18,370	0	18,370	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,500	0	1,500	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	614	0	614	0	88.02
90.00	09000	CLINIC	136,179	615	0	615	0	90.00
90.01	04951	CHEMO/PAIN	947,747	1,236	0	1,236	0	90.01
90.02	09002	SENIOR CARE	429,374	1,600	0	1,600	0	90.02
90.03	09003	SLEEP LAB	106,615	130	0	130	0	90.03
91.00	09100	EMERGENCY	2,013,452	5,154	0	5,154	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,716,917	80,305	100	78,651	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	4,396	0	4,396	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	0	2,145	0	2,145	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,178,926	1,633,713	201,307	359,110	475,977	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.066542	18.811609	2,013.070000	4.215302	4,759.770000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	78,299	252,452	23,990	19,421	74,793	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.004419	2.906893	239.900000	0.227967	747.930000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/18/2016 12:34 pm

		Cost Center Description	CAFETERIA (GROSS SALARIES)	NURSING ADMINISTRATION (NRSNG SALARIES)	PHARMACY (COST REQU.)	MEDICAL RECORDS & LIBRARY (GROSS REV)	SOCIAL SERVICE (PAT DAYS)	
			11.00	13.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00590	OTHER ADMINISTRATIVE AND GENERAL						5.01
5.02	00560	ADMITTING						5.02
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	14,901,648					11.00
13.00	01300	NURSING ADMINISTRATION	810,040	4,085,588				13.00
15.00	01500	PHARMACY	126,314	0	1,927,292			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	443,171	0	0	74,456,717		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	100	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,643,489	1,388,706	14	2,312,351	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,194,515	1,159,392	1,380	9,457,654	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	27	1,482,245	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	875,754	0	1,752	19,525,353	0	54.00
60.00	06000	LABORATORY	728,680	0	4	12,419,004	0	60.00
65.00	06500	RESPIRATORY THERAPY	295,794	0	1,932	487,746	0	65.00
66.00	06600	PHYSICAL THERAPY	891,820	0	1,258	6,693,434	0	66.00
69.00	06900	ELECTROCARDIOLOGY	49,848	0	0	1,157,638	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	10,246	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	6,781,238	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,551,035	6,760,013	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,566,682	0	341,812	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	169,090	0	22,070	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	21,894	0	93	0	0	88.02
90.00	09000	CLINIC	80,891	0	205	180,314	0	90.00
90.01	04951	CHEMO/PAIN	817,393	541,025	2,968	1,175,040	0	90.01
90.02	09002	SENIOR CARE	553	553	0	438,157	0	90.02
90.03	09003	SLEEP LAB	62,601	0	0	374,995	0	90.03
91.00	09100	EMERGENCY	1,046,869	995,912	834	5,201,289	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,825,398	4,085,588	1,925,384	74,456,717	100	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2,075,500	0	1,671	0	0	192.00
192.01	19202	OCCUPATIONAL MEDICINE	750	0	237	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	415,802	1,348,369	254,174	810,156	77,032	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.027903	0.330031	0.131881	0.010881	770.320000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	36,341	48,405	22,873	60,689	4,368	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.002439	0.011848	0.011868	0.000815	43.680000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/18/2016 12:34 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	4,364,884		4,364,884	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,334,371		3,334,371	0	0	50.00
53.00	05300	ANESTHESIOLOGY	88,389		88,389	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,672,899		2,672,899	0	0	54.00
60.00	06000	LABORATORY	2,494,513		2,494,513	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	545,371	0	545,371	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,791,843	0	1,791,843	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	119,984		119,984	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,719		14,719	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,152,288		1,152,288	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,738,922		1,738,922	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,128,656		2,128,656	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,492,140		7,492,140	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	384,502		384,502	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	64,926		64,926	0	0	88.02
90.00	09000	CLINIC	183,012		183,012	0	0	90.00
90.01	04951	CHEMO/PAIN	1,374,293		1,374,293	0	0	90.01
90.02	09002	SENIOR CARE	555,188		555,188	0	0	90.02
90.03	09003	SLEEP LAB	136,074		136,074	0	0	90.03
91.00	09100	EMERGENCY	2,852,201		2,852,201	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	353,746		353,746		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	33,842,921	0	33,842,921	0	0	200.00
201.00		Less Observation Beds	353,746		353,746		0	201.00
202.00		Total (see instructions)	33,489,175	0	33,489,175	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/18/2016 12:34 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	2,046,067		2,046,067			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,354,127	7,103,527	9,457,654	0.352558	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	409,983	1,072,262	1,482,245	0.059632	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	593,179	18,932,174	19,525,353	0.136894	0.000000	54.00
60.00	06000	LABORATORY	689,177	11,729,826	12,419,003	0.200863	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	332,047	155,699	487,746	1.118146	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,137,246	5,556,188	6,693,434	0.267702	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	16,754	1,140,884	1,157,638	0.103646	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,246	10,246	1.436561	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,399,955	2,422,230	3,822,185	0.301474	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,297,709	661,343	2,959,052	0.587662	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,212,515	5,547,499	6,760,014	0.314889	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,641,154	6,641,154			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	315,320	315,320			88.01
88.02	08802	RURAL HEALTH CLINIC III	0	27,638	27,638			88.02
90.00	09000	CLINIC	0	180,314	180,314	1.014963	0.000000	90.00
90.01	04951	CHEMO/PAIN	630	1,174,410	1,175,040	1.169571	0.000000	90.01
90.02	09002	SENIOR CARE	0	438,157	438,157	1.267098	0.000000	90.02
90.03	09003	SLEEP LAB	0	374,995	374,995	0.362869	0.000000	90.03
91.00	09100	EMERGENCY	66,904	5,134,386	5,201,290	0.548364	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,818	260,467	266,285	1.328449	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,562,111	68,878,719	81,440,830			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,562,111	68,878,719	81,440,830			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/18/2016 12:34 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
88.02	08802	RURAL HEALTH CLINIC III		88.02
90.00	09000	CLINIC	0.000000	90.00
90.01	04951	CHEMO/PAIN	0.000000	90.01
90.02	09002	SENIOR CARE	0.000000	90.02
90.03	09003	SLEEP LAB	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/18/2016 12:34 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	4,364,884		4,364,884	0	4,364,884	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,334,371		3,334,371	0	3,334,371	50.00
53.00	05300	ANESTHESIOLOGY	88,389		88,389	0	88,389	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,672,899		2,672,899	0	2,672,899	54.00
60.00	06000	LABORATORY	2,494,513		2,494,513	0	2,494,513	60.00
65.00	06500	RESPIRATORY THERAPY	545,371	0	545,371	0	545,371	65.00
66.00	06600	PHYSICAL THERAPY	1,791,843	0	1,791,843	0	1,791,843	66.00
69.00	06900	ELECTROCARDIOLOGY	119,984		119,984	0	119,984	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,719		14,719	0	14,719	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,152,288		1,152,288	0	1,152,288	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	1,738,922		1,738,922	0	1,738,922	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,128,656		2,128,656	0	2,128,656	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,492,140		7,492,140	0	7,492,140	88.00
88.01	08801	RURAL HEALTH CLINIC II	384,502		384,502	0	384,502	88.01
88.02	08802	RURAL HEALTH CLINIC III	64,926		64,926	0	64,926	88.02
90.00	09000	CLINIC	183,012		183,012	0	183,012	90.00
90.01	04951	CHEMO/PAIN	1,374,293		1,374,293	0	1,374,293	90.01
90.02	09002	SENIOR CARE	555,188		555,188	0	555,188	90.02
90.03	09003	SLEEP LAB	136,074		136,074	0	136,074	90.03
91.00	09100	EMERGENCY	2,852,201		2,852,201	0	2,852,201	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	353,746		353,746		353,746	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	33,842,921	0	33,842,921	0	33,842,921	200.00
201.00		Less Observation Beds	353,746		353,746		353,746	201.00
202.00		Total (see instructions)	33,489,175	0	33,489,175	0	33,489,175	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/18/2016 12:34 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	2,046,067		2,046,067			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,354,127	7,103,527	9,457,654	0.352558	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	409,983	1,072,262	1,482,245	0.059632	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	593,179	18,932,174	19,525,353	0.136894	0.000000	54.00
60.00	06000	LABORATORY	689,177	11,729,826	12,419,003	0.200863	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	332,047	155,699	487,746	1.118146	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	1,137,246	5,556,188	6,693,434	0.267702	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	16,754	1,140,884	1,157,638	0.103646	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,246	10,246	1.436561	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,399,955	2,422,230	3,822,185	0.301474	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,297,709	661,343	2,959,052	0.587662	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,212,515	5,547,499	6,760,014	0.314889	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,641,154	6,641,154	1.128138	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	315,320	315,320	1.219403	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	27,638	27,638	2.349157	0.000000	88.02
90.00	09000	CLINIC	0	180,314	180,314	1.014963	0.000000	90.00
90.01	04951	CHEMO/PAIN	630	1,174,410	1,175,040	1.169571	0.000000	90.01
90.02	09002	SENIOR CARE	0	438,157	438,157	1.267098	0.000000	90.02
90.03	09003	SLEEP LAB	0	374,995	374,995	0.362869	0.000000	90.03
91.00	09100	EMERGENCY	66,904	5,134,386	5,201,290	0.548364	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	5,818	260,467	266,285	1.328449	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,562,111	68,878,719	81,440,830			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	12,562,111	68,878,719	81,440,830			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/18/2016 12:34 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
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000	88.02
90.00	09000	CLINIC	0.000000	90.00
90.01	04951	CHEMO/PAIN	0.000000	90.01
90.02	09002	SENIOR CARE	0.000000	90.02
90.03	09003	SLEEP LAB	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/18/2016 12:34 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	294,001	9,457,654	0.031086	1,138,271	35,384	50.00
53.00	05300	ANESTHESIOLOGY	4,900	1,482,245	0.003306	191,909	634	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	219,128	19,525,353	0.011223	280,200	3,145	54.00
60.00	06000	LABORATORY	114,495	12,419,003	0.009219	345,249	3,183	60.00
65.00	06500	RESPIRATORY THERAPY	17,447	487,746	0.035771	151,227	5,410	65.00
66.00	06600	PHYSICAL THERAPY	131,524	6,693,434	0.019650	281,725	5,536	66.00
69.00	06900	ELECTROCARDIOLOGY	14,417	1,157,638	0.012454	9,789	122	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,163	10,246	0.699102	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,556	3,822,185	0.005378	719,104	3,867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	24,234	2,959,052	0.008190	1,207,255	9,887	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,706	6,760,014	0.007353	564,136	4,148	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	511,903	6,641,154	0.077080	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	38,892	315,320	0.123341	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	14,676	27,638	0.531008	0	0	88.02
90.00	09000	CLINIC	16,794	180,314	0.093138	0	0	90.00
90.01	04951	CHEMO/PAIN	54,279	1,175,040	0.046193	74	3	90.01
90.02	09002	SENIOR CARE	44,145	438,157	0.100752	0	0	90.02
90.03	09003	SLEEP LAB	5,271	374,995	0.014056	0	0	90.03
91.00	09100	EMERGENCY	170,217	5,201,290	0.032726	2,061	67	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	56,380	266,285	0.211728	0	0	92.00
200.00		Total (lines 50-199)	1,810,128	79,394,763		4,891,000	71,386	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 12:34 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
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0	0	0	88.02
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	0	0	0	0	0	90.01
90.02	09002	SENIOR CARE	0	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV Date/Time Prepared: 5/18/2016 12:34 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	9,457,654	0.000000	0.000000	1,138,271	50.00
53.00	05300	ANESTHESIOLOGY	0	1,482,245	0.000000	0.000000	191,909	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	19,525,353	0.000000	0.000000	280,200	54.00
60.00	06000	LABORATORY	0	12,419,003	0.000000	0.000000	345,249	60.00
65.00	06500	RESPIRATORY THERAPY	0	487,746	0.000000	0.000000	151,227	65.00
66.00	06600	PHYSICAL THERAPY	0	6,693,434	0.000000	0.000000	281,725	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,157,638	0.000000	0.000000	9,789	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	10,246	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3,822,185	0.000000	0.000000	719,104	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,959,052	0.000000	0.000000	1,207,255	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,760,014	0.000000	0.000000	564,136	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	6,641,154	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	315,320	0.000000	0.000000	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0	27,638	0.000000	0.000000	0	88.02
90.00	09000	CLINIC	0	180,314	0.000000	0.000000	0	90.00
90.01	04951	CHEMO/PAIN	0	1,175,040	0.000000	0.000000	74	90.01
90.02	09002	SENIOR CARE	0	438,157	0.000000	0.000000	0	90.02
90.03	09003	SLEEP LAB	0	374,995	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	5,201,290	0.000000	0.000000	2,061	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	266,285	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	79,394,763			4,891,000	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/18/2016 12:34 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
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0	0		88.02
90.00	09000	CLINIC	0	0	0		90.00
90.01	04951	CHEMO/PAIN	0	0	0		90.01
90.02	09002	SENIOR CARE	0	0	0		90.02
90.03	09003	SLEEP LAB	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/18/2016 12:34 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	0.352558	0	1,742,017	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.059632	0	247,976	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136894	0	5,520,250	0	0	54.00
60.00	06000	LABORATORY	0.200863	0	3,985,840	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.118146	0	46,816	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.267702	0	1,708,786	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.103646	0	374,561	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.436561	0	4,391	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.301474	0	625,971	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.587662	0	148,130	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.314889	0	1,975,971	60	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	1.014963	0	63,700	0	0	90.00
90.01	04951	CHEMO/PAIN	1.169571	0	353,026	120	0	90.01
90.02	09002	SENIOR CARE	1.267098	0	414,339	0	0	90.02
90.03	09003	SLEEP LAB	0.362869	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.548364	0	1,289,113	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.328449	0	67,316	0	0	92.00
200.00		Subtotal (see instructions)		0	18,568,203	180	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	18,568,203	180	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/18/2016 12:34 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	614,162	0		50.00
53.00	05300	ANESTHESIOLOGY	14,787	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	755,689	0		54.00
60.00	06000	LABORATORY	800,608	0		60.00
65.00	06500	RESPIRATORY THERAPY	52,347	0		65.00
66.00	06600	PHYSICAL THERAPY	457,445	0		66.00
69.00	06900	ELECTROCARDIOLOGY	38,822	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,308	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	188,714	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	87,050	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	622,212	19		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	64,653	0		90.00
90.01	04951	CHEMO/PAIN	412,889	140		90.01
90.02	09002	SENIOR CARE	525,008	0		90.02
90.03	09003	SLEEP LAB	0	0		90.03
91.00	09100	EMERGENCY	706,903	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	89,426	0		92.00
200.00		Subtotal (see instructions)	5,437,023	159		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,437,023	159		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141320 | Component CCN: 14Z320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/18/2016 12:34 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	0.352558	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.059632	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136894	0	0	0	0	54.00
60.00	06000	LABORATORY	0.200863	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.118146	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.267702	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.103646	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.436561	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.301474	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.587662	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.314889	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000				0	88.02
90.00	09000	CLINIC	1.014963	0	0	0	0	90.00
90.01	04951	CHEMO/PAIN	1.169571	0	0	0	0	90.01
90.02	09002	SENIOR CARE	1.267098	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0.362869	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.548364	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.328449	0	0	0	0	92.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141320 | Component CCN: 14Z320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/18/2016 12:34 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
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	0	0		90.00
90.01	04951	CHEMO/PAIN	0	0		90.01
90.02	09002	SENIOR CARE	0	0		90.02
90.03	09003	SLEEP LAB	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/18/2016 12:34 pm

Title XIX | 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	0.352558	0	0	1,767,860	0	50.00
53.00	05300	ANESTHESIOLOGY	0.059632	0	0	267,097	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136894	0	0	5,087,596	0	54.00
60.00	06000	LABORATORY	0.200863	0	0	2,234,813	0	60.00
65.00	06500	RESPIRATORY THERAPY	1.118146	0	0	47,984	0	65.00
66.00	06600	PHYSICAL THERAPY	0.267702	0	0	1,270,384	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.103646	0	0	280,836	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.436561	0	0	4,099	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.301474	0	0	835,821	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.587662	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.314889	0	0	1,150,588	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1.128138				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.219403				0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2.349157				0	88.02
90.00	09000	CLINIC	1.014963	0	0	7,643	0	90.00
90.01	04951	CHEMO/PAIN	1.169571	0	0	16,106	0	90.01
90.02	09002	SENIOR CARE	1.267098	0	0	0	0	90.02
90.03	09003	SLEEP LAB	0.362869	0	0	126,976	0	90.03
91.00	09100	EMERGENCY	0.548364	0	0	1,867,698	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.328449	0	0	68,881	0	92.00
200.00		Subtotal (see instructions)		0	0	15,034,382	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	15,034,382	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/18/2016 12:34 pm

Title XIX | 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	0	623,273		50.00
53.00	05300	ANESTHESIOLOGY	0	15,928		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	696,461		54.00
60.00	06000	LABORATORY	0	448,891		60.00
65.00	06500	RESPIRATORY THERAPY	0	53,653		65.00
66.00	06600	PHYSICAL THERAPY	0	340,084		66.00
69.00	06900	ELECTROCARDIOLOGY	0	29,108		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,888		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	251,978		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	362,308		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0		88.01
88.02	08802	RURAL HEALTH CLINIC III	0	0		88.02
90.00	09000	CLINIC	0	7,757		90.00
90.01	04951	CHEMO/PAIN	0	18,837		90.01
90.02	09002	SENIOR CARE	0	0		90.02
90.03	09003	SLEEP LAB	0	46,076		90.03
91.00	09100	EMERGENCY	0	1,024,178		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	91,505		92.00
200.00		Subtotal (see instructions)	0	4,015,925		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	4,015,925		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 12:34 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)	4,807	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,742	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,540	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	584	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	2,481	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)	957	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)	584	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	117.51	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	117.51	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,364,884	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)	291,542	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)	1,314,254	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,050,630	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,050,630	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,751.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,675,918	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,675,918	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 12:34 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)						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)	1,871,090	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,547,008	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	1,022,712	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,022,712	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)	202	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,751.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	353,746	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 12:34 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	486,206	3,050,630	0.159379	353,746	56,380	90.00
91.00	Nursing School cost	0	3,050,630	0.000000	353,746	0	91.00
92.00	Allied health cost	0	3,050,630	0.000000	353,746	0	92.00
93.00	All other Medical Education	0	3,050,630	0.000000	353,746	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 12:34 pm

Title XIX | 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)	4,807	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,742	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,540	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	584	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	2,481	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)	184	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	117.51	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	117.51	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,364,884	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)	291,542	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)	1,314,254	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,050,630	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,050,630	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,751.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	322,224	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)	322,224	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 12:34 pm

Title XIX | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		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)	458,578	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	780,802	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	202	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,751.22	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	353,746	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/18/2016 12:34 pm

Title XIX | 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	486,206	3,050,630	0.159379	353,746	56,380	90.00
91.00	Nursing School cost	0	3,050,630	0.000000	353,746	0	91.00
92.00	Allied health cost	0	3,050,630	0.000000	353,746	0	92.00
93.00	All other Medical Education	0	3,050,630	0.000000	353,746	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/18/2016 12:34 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		815,137		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.352558	1,138,271	401,307	50.00
53.00	05300	ANESTHESIOLOGY	0.059632	191,909	11,444	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136894	280,200	38,358	54.00
60.00	06000	LABORATORY	0.200863	345,249	69,348	60.00
65.00	06500	RESPIRATORY THERAPY	1.118146	151,227	169,094	65.00
66.00	06600	PHYSICAL THERAPY	0.267702	281,725	75,418	66.00
69.00	06900	ELECTROCARDIOLOGY	0.103646	9,789	1,015	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.436561	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.301474	719,104	216,791	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.587662	1,207,255	709,458	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.314889	564,136	177,640	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	1.014963	0	0	90.00
90.01	04951	CHEMO/PAIN	1.169571	74	87	90.01
90.02	09002	SENIOR CARE	1.267098	0	0	90.02
90.03	09003	SLEEP LAB	0.362869	0	0	90.03
91.00	09100	EMERGENCY	0.548364	2,061	1,130	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.328449	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		4,891,000	1,871,090	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)		4,891,000		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3

Component CCN: 14Z320 | Date/Time Prepared: 5/18/2016 12:34 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
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.352558	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.059632	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136894	22,488	3,078	54.00
60.00	06000	LABORATORY	0.200863	30,052	6,036	60.00
65.00	06500	RESPIRATORY THERAPY	1.118146	55,727	62,311	65.00
66.00	06600	PHYSICAL THERAPY	0.267702	401,829	107,570	66.00
69.00	06900	ELECTROCARDIOLOGY	0.103646	377	39	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.436561	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.301474	35,335	10,653	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.587662	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.314889	127,721	40,218	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
88.02	08802	RURAL HEALTH CLINIC III	0.000000		0	88.02
90.00	09000	CLINIC	1.014963	0	0	90.00
90.01	04951	CHEMO/PAIN	1.169571	0	0	90.01
90.02	09002	SENIOR CARE	1.267098	0	0	90.02
90.03	09003	SLEEP LAB	0.362869	0	0	90.03
91.00	09100	EMERGENCY	0.548364	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.328449	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		673,529	229,905	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)		673,529		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/18/2016 12:34 pm

Title XIX | 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		199,252		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.352558	407,554	143,686	50.00
53.00	05300	ANESTHESIOLOGY	0.059632	72,599	4,329	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.136894	102,636	14,050	54.00
60.00	06000	LABORATORY	0.200863	99,205	19,927	60.00
65.00	06500	RESPIRATORY THERAPY	1.118146	26,690	29,843	65.00
66.00	06600	PHYSICAL THERAPY	0.267702	48,979	13,112	66.00
69.00	06900	ELECTROCARDIOLOGY	0.103646	2,824	293	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1.436561	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.301474	527,334	158,977	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.587662	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.314889	160,814	50,639	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	1.128138	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1.219403	0	0	88.01
88.02	08802	RURAL HEALTH CLINIC III	2.349157	0	0	88.02
90.00	09000	CLINIC	1.014963	0	0	90.00
90.01	04951	CHEMO/PAIN	1.169571	0	0	90.01
90.02	09002	SENIOR CARE	1.267098	0	0	90.02
90.03	09003	SLEEP LAB	0.362869	0	0	90.03
91.00	09100	EMERGENCY	0.548364	31,678	17,371	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.328449	4,781	6,351	92.00
200.00		Total (sum of lines 50-94 and 96-98)		1,485,094	458,578	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)		1,485,094		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141320	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/18/2016 12:34 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,437,182	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,437,182	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)	5,491,554	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)	35,362	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,920,717	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	2,535,475	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,535,475	30.00
31.00	Primary payer payments	1,578	31.00
32.00	Subtotal (line 30 minus line 31)	2,533,897	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)	634,169	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	412,210	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	2,946,107	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,946,107	40.00
40.01	Sequestration adjustment (see instructions)	58,922	40.01
41.00	Interim payments	2,971,614	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-84,429	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/18/2016 12:34 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,396,858		3,052,795	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		40,577		508,808	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	08/19/2015	80,925	08/19/2015	323,407	3.50
3.51		12/15/2015	63,326	12/15/2015	266,582	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)		-144,251		-589,989	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,293,184		2,971,614	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		964,961		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		84,429	6.02
7.00	Total Medicare program liability (see instructions)		3,258,145		2,887,185	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: 141320 | Component CCN: 14Z320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/18/2016 12:34 pm

Title XVIII | Swing Beds - SNF | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,016,652		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	08/19/2015	36,754		0	3.50
3.51		12/15/2015	24,809		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)		-61,563		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)		955,089		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		282,744		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,237,833		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 141320	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/18/2016 12:34 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	530	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	957	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	1,540	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	81,440,830	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	661,868	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	1	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	1	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1	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)	1	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 141320 | Component CCN: 14Z320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-2 | Date/Time Prepared: 5/18/2016 12:34 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)	1,032,939	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)	232,204	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	584	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)	1,265,143	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	1,265,143	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)	1,265,143	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,048	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)	1,263,095	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)	1,263,095	0	19.00
19.01	Sequestration adjustment (see instructions)	25,262	0	19.01
20.00	Interim payments	955,089	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)	282,744	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: 141320	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prepared: 5/18/2016 12:34 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3,547,008	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,547,008	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3,582,478	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3,582,478	19.00
20.00	Deductibles (exclude professional component)	304,400	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,278,078	22.00
23.00	Coinsurance	1,575	23.00
24.00	Subtotal (line 22 minus line 23)	3,276,503	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	74,054	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	48,135	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3,324,638	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	3,324,638	30.00
30.01	Sequestration adjustment (see instructions)	66,493	30.01
31.00	Interim payments	2,293,184	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)	964,961	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	162,954	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/18/2016 12:34 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	7,697,336	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	25,091,967	0	0	0	4.00
5.00	Other receivable	1,867,058	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-14,569,010	0	0	0	6.00
7.00	Inventory	1,345,440	0	0	0	7.00
8.00	Prepaid expenses	474,496	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)	21,907,287	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	41,344,516	0	0	0	15.00
16.00	Accumulated depreciation	-26,580,079	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)	14,764,437	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	18,283,098	0	0	0	33.00
34.00	Other assets	150,104	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	18,433,202	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	55,104,926	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,448,628	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	2,160,883	0	0	0	39.00
40.00	Notes and loans payable (short term)	385,367	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	554,999	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	5,549,877	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	2,616,025	0	0	0	46.00
47.00	Notes payable	0	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	2,616,025	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	8,165,902	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	46,939,024				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)	46,939,024	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	55,104,926	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/18/2016 12:34 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		42,539,085		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		4,209,011				2.00
3.00	Total (sum of line 1 and line 2)		46,748,096		0		3.00
4.00	MISCELLANEOUS	190,928		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		190,928		0		10.00
11.00	Subtotal (line 3 plus line 10)		46,939,024		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		46,939,024		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	MISCELLANEOUS		0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/18/2016 12:34 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,854,066		1,854,066	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	728,285		728,285	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2,582,351		2,582,351	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				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)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2,582,351		2,582,351	17.00
18.00	Ancillary services	10,509,596	59,841,259	70,350,855	18.00
19.00	Outpatient services	630	1,792,881	1,793,511	19.00
20.00	RURAL HEALTH CLINIC	0	6,641,154	6,641,154	20.00
20.01	RURAL HEALTH CLINIC II	0	315,320	315,320	20.01
20.02	RURAL HEALTH CLINIC III	0	27,638	27,638	20.02
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	1,725,865	15,991,640	17,717,505	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	14,818,442	84,609,892	99,428,334	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		42,203,979		29.00
30.00		0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		42,203,979		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141320 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-3 | Date/Time Prepared: 5/18/2016 12:34 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	99,428,334	1.00
2.00	Less contractual allowances and discounts on patients' accounts	54,907,666	2.00
3.00	Net patient revenues (line 1 minus line 2)	44,520,668	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	42,203,979	4.00
5.00	Net income from service to patients (line 3 minus line 4)	2,316,689	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	1,706,704	24.00
24.01	NON-OPERATING INCOME	185,618	24.01
25.00	Total other income (sum of lines 6-24)	1,892,322	25.00
26.00	Total (line 5 plus line 25)	4,209,011	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	4,209,011	29.00

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

Provider CCN: 141320 Component CCN: 143987 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/18/2016 12:34 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	1,587,473	0	1,587,473	0	1,587,473	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	315,872	0	315,872	0	315,872	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	764,534	0	764,534	0	764,534	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	2,514	0	2,514	0	2,514	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)	2,670,393	0	2,670,393	0	2,670,393	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	6,377	6,377	0	6,377	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	83,199	83,199	0	83,199	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	89,576	89,576	0	89,576	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	2,670,393	89,576	2,759,969	0	2,759,969	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	341,812	341,812	0	341,812	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	508,739	508,739	0	508,739	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	850,551	850,551	0	850,551	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	896,289	621,728	1,518,017	-27,170	1,490,847	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	896,289	621,728	1,518,017	-27,170	1,490,847	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	3,566,682	1,561,855	5,128,537	-27,170	5,101,367	32.00

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

Provider CCN: 141320 | Component CCN: 143987 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/18/2016 12:34 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	1,587,473		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	315,872		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	764,534		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	2,514		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	2,670,393		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	6,377		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	83,199		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	89,576		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	2,759,969		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	341,812		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	508,739		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	850,551		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-184,624	1,306,223		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-184,624	1,306,223		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-184,624	4,916,743		32.00

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

Provider CCN: 141320 Component CCN: 143989 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/18/2016 12:34 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	13,057	0	13,057	0	13,057	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	102,310	0	102,310	0	102,310	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	28,047	0	28,047	0	28,047	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	793	0	793	0	793	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)	144,207	0	144,207	0	144,207	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	199	199	0	199	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	199	199	0	199	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	144,207	199	144,406	0	144,406	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	17,792	17,792	0	17,792	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	17,792	17,792	0	17,792	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	24,883	82,792	107,675	-30,966	76,709	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	24,883	82,792	107,675	-30,966	76,709	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	169,090	100,783	269,873	-30,966	238,907	32.00

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

Provider CCN: 141320 | Component CCN: 143989 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/18/2016 12:34 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	13,057		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	102,310		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	28,047		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	793		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	144,207		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	199		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	199		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	144,406		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	17,792		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	17,792		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-5,762	70,947		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-5,762	70,947		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-5,762	233,145		32.00

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

Provider CCN: 141320 Component CCN: 143431 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/18/2016 12:34 pm

Rural Health Clinic (RHC) III | 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	3,185	0	3,185	0	3,185	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	12,250	0	12,250	0	12,250	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	6,420	0	6,420	0	6,420	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	39	0	39	0	39	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)	21,894	0	21,894	0	21,894	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	0	0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0	0	0	0	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	21,894	0	21,894	0	21,894	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	93	93	0	93	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	699	699	0	699	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	792	792	0	792	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	10,473	10,473	-5,879	4,594	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	10,473	10,473	-5,879	4,594	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	21,894	11,265	33,159	-5,879	27,280	32.00

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

Provider CCN: 141320 | Component CCN: 143431 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/18/2016 12:34 pm

Rural Health Clinic (RHC) III | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	3,185		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	12,250		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	6,420		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	39		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	21,894		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	0		15.00
16.00	Transportation (Health Care Staff)	0	0		16.00
17.00	Depreciation-Medical Equipment	0	0		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	21,894		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	93		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	699		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	792		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	-200	4,394		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-200	4,394		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-200	27,080		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141320 | Component CCN: 143987 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-2 | Date/Time Prepared: 5/18/2016 12:34 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	4.10	28,423	4,200	17,220		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	2.47	7,986	2,100	5,187		3.00
4.00	Subtotal (sum of lines 1 through 3)	6.57	36,409		22,407	36,409	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)	6.57	36,409			36,409	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)					2,759,969	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					850,551	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					3,610,520	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.764424	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					1,306,223	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					2,575,397	15.00
16.00	Total overhead (sum of lines 14 and 15)					3,881,620	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					3,881,620	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					2,967,203	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					5,727,172	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141320 Component CCN: 143989

Period: From 01/01/2015 To 12/31/2015

Worksheet M-2

Date/Time Prepared: 5/18/2016 12:34 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	0.01	0	4,200	42		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.96	1,572	2,100	2,016		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.97	1,572		2,058	2,058	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)	0.97	1,572			2,058	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)					144,406	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					17,792	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					162,198	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.890307	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					70,947	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					151,357	15.00
16.00	Total overhead (sum of lines 14 and 15)					222,304	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					222,304	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					197,919	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					342,325	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141320 | Component CCN: 143431 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-2 | Date/Time Prepared: 5/18/2016 12:34 pm

Rural Health Clinic (RHC) III | 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	0.01	1	4,200	42		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.16	141	2,100	336		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.17	142		378	378	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)	0.17	142			378	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)					21,894	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					792	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					22,686	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)					0.965089	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)					4,394	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					37,846	15.00
16.00	Total overhead (sum of lines 14 and 15)					42,240	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					42,240	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					40,765	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					62,659	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141320 | Component CCN: 143987 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-3 | Date/Time Prepared: 5/18/2016 12:34 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)		5,727,172	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		28,001	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		5,699,171	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		36,409	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)		36,409	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		156.53	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)	163.87	163.87	8.00
9.00	Rate for Program covered visits (see instructions)	156.53	156.53	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	8,265	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,293,720	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		1,293,720	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,031,743	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		20,429	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		25,616	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.)		929,970	16.04
16.05	Total program cost (see instructions)		955,586	16.05
17.00	Primary payer amounts		80	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		105,642	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		181,134	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		955,506	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		27,999	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		983,505	22.00
23.00	Allowable bad debts (see instructions)		66,038	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		42,925	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)		1,026,430	26.00
26.01	Sequestration adjustment (see instructions)		20,529	26.01
27.00	Interim payments		948,761	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)		57,140	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: 141320 | Component CCN: 143989 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-3 | Date/Time Prepared: 5/18/2016 12:34 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)		342,325	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		3,708	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		338,617	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		2,058	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		2,058	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		164.54	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)	187.22	187.22	8.00
9.00	Rate for Program covered visits (see instructions)	164.54	164.54	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	302	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	49,691	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) *		49,691	16.00
16.01	Total program charges (see instructions)(from contractor's records)		38,556	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		3,683	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		4,747	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.)		31,241	16.04
16.05	Total program cost (see instructions)		35,988	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		5,893	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		5,796	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		35,988	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,708	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		39,696	22.00
23.00	Allowable bad debts (see instructions)		994	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		646	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)		40,342	26.00
26.01	Sequestration adjustment (see instructions)		807	26.01
27.00	Interim payments		41,556	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)		-2,021	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: 141320 | Component CCN: 143431 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-3 | Date/Time Prepared: 5/18/2016 12:34 pm

Title XVIII | Rural Health Clinic (RHC) III | 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)		62,659	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		454	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		62,205	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		378	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)		378	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		164.56	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)	194.56	194.56	8.00
9.00	Rate for Program covered visits (see instructions)	164.56	164.56	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	22	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	3,620	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) *		3,620	16.00
16.01	Total program charges (see instructions)(from contractor's records)		2,298	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		111	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		175	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.)		2,077	16.04
16.05	Total program cost (see instructions)		2,252	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		849	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		268	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		2,252	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		454	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		2,706	22.00
23.00	Allowable bad debts (see instructions)		403	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		262	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)		2,968	26.00
26.01	Sequestration adjustment (see instructions)		59	26.01
27.00	Interim payments		2,427	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)		482	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: 141320 | Component CCN: 143987 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-4 | Date/Time Prepared: 5/18/2016 12:34 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)	2,670,393	2,670,393	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)	4,036	7,600	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	4,036	7,600	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	2,759,969	2,759,969	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	3,881,620	3,881,620	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001462	0.002754	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	5,675	10,690	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	9,711	18,290	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	26	478	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	373.50	38.26	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	26	478	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	9,711	18,288	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)		28,001	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)		27,999	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141320 | Component CCN: 143989 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-4 | Date/Time Prepared: 5/18/2016 12:34 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)	144,207	144,207	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)	776	684	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	776	684	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	144,406	144,406	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	222,304	222,304	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.005374	0.004737	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,195	1,053	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	1,971	1,737	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	5	43	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	394.20	40.40	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	5	43	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	1,971	1,737	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)		3,708	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)		3,708	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141320 | Component CCN: 143431 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-4 | Date/Time Prepared: 5/18/2016 12:34 pm

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	21,894	21,894	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)	155	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	155	0	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	21,894	21,894	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	42,240	42,240	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.007080	0.000000	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	299	0	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	454	0	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1	0	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	454.00	0.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	1	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	454	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)		454	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)		454	16.00

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

Provider CCN: 141320 | Component CCN: 143987 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-5 | Date/Time Prepared: 5/18/2016 12:34 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		892,094	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		08/19/2015	28,491	3.01
3.02		12/15/2015	28,176	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)		56,667	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		948,761	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		57,140	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,005,901	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: 141320 | Component CCN: 143989 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-5 | Date/Time Prepared: 5/18/2016 12:34 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		36,453	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		08/19/2015	5,103	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)		5,103	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		41,556	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		0	6.01
6.02	SETTLEMENT TO PROGRAM		2,021	6.02
7.00	Total Medicare program liability (see instructions)		39,535	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: 141320 Component CCN: 143431	Period: From 01/01/2015 To 12/31/2015	Worksheet M-5 Date/Time Prepared: 5/18/2016 12:34 pm
		Rural Health Clinic (RHC) III	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		2,427	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)		2,427	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		482	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		2,909	7.00

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