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: 141321	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/23/2015 10:16 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/23/2015 Time: 10:16 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FRANKLIN HOSPITAL (141321) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	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	-149,593	-218,052	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-14,587	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		111,144		0	10.00
10.01	RURAL HEALTH CLINIC II	0		127,063		0	10.01
200.00	Total	0	-164,180	20,155	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/23/2015 9:56 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 201 BAILEY LANE	PO Box:			1.00
2.00	City: BENTON	State: IL	Zip Code: 62812	County: FRANKLIN	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	FRANKLIN HOSPITAL	141321	14999	1	08/01/2002	N	O	N	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	FRANKLIN HOSPITAL SWING BED	14Z321	14999		08/01/2002	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	FRANKLIN RHC	143469	14999		07/06/2005	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	WEST FRANKFORT RHC	148510	14999		04/23/2010	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2014	06/30/2015	20.00
21.00	Type of Control (see instructions)	9		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
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/23/2015 9:56 am

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 9:56 am

		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	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 9:56 am

		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
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	N	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

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		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 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.	Y	Y	Y	N	109.00

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	264,308	0	0	118.01

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 9:56 am

		1.00	2.00	
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	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

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	07/01/2014	09/30/2014	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141321	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 9:56 am

		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: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/23/2015 9:56 am

			Y/N	Date	
			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
	COMPLETED BY ALL HOSPITALS				
	Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
	Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for 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	10/20/2015	Y
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II Date/Time Prepared: 11/23/2015 9:56 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				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.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	RSM US LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(563) 888-4404	DAN.LINHART@RSMUS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 11/23/2015 9:56 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	10/20/2015			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		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: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/23/2015 9:56 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	22,272.00	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	22,272.00	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	22,272.00	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
26.25	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: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 11/23/2015 9:56 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	885	167	1,318			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	96	0	145			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	31			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	981	167	1,494			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)	981	167	1,494	0.00	123.44	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	8,414	4,861	20,033	0.00	26.90	26.00
26.01	RURAL HEALTH CLINIC II	1,193	903	3,567	0.00	5.71	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	156.05	27.00
28.00	Observation Bed Days		0	89			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: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/23/2015 9:56 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	272	67	485	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	272	67	485	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
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

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

Provider CCN: 141321 Component CCN: 143469 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-8 Date/Time Prepared: 11/23/2015 9:56 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	201 BAILEY LANE	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	BENTON	IL	62812	2.00

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic	12:00	18:00	09:00	20:00	09:00	11.00

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

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

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

			County				
			4.00				
2.00	City, State, ZIP Code, County						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	20:00	09:00	20:00	09:00	20:00	11.00

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

Provider CCN: 141321
Component CCN: 143469

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

Worksheet S-8

Date/Time Prepared:
11/23/2015 9:56 am

Rural Health Clinic (RHC) I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	09:00	20:00	09:00	19:00		11.00

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

Provider CCN: 141321 Component CCN: 148510 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-8 | Date/Time Prepared: 11/23/2015 9:56 am

		Rural Health Clinic (RHC) II	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	309 WEST ST. LOUIS STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	WEST FRANKFORT	IL	62896	2.00

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

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

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

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:30	17:00	08:30	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

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	17:00	08:30	17:00	08:30	17:00	11.00

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

Provider CCN: 141321 Component CCN: 148510

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

Worksheet S-8

Date/Time Prepared: 11/23/2015 9:56 am

Rural Health Clinic (RHC) II

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:30	17:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 11/23/2015 9:56 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.416980	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	2,538,721	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	1,458,266	5.00
6.00	Medicaid charges	10,849,073	6.00
7.00	Medicaid cost (line 1 times line 6)	4,523,846	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)	526,859	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)	526,859	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	138,196	44,141	182,337	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	57,625	18,406	76,031	21.00
22.00	Partial payment by patients approved for charity care	1,435	1,150	2,585	22.00
23.00	Cost of charity care (line 21 minus line 22)	56,190	17,256	73,446	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	1,917,099	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	442,719	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	1,474,380	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	614,787	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	688,233	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,215,092	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/23/2015 9:56 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		133,384	133,384	126,642	260,026	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		390,626	390,626	48,290	438,916	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	64,825	957,109	1,021,934	30,725	1,052,659	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,138,372	1,402,315	2,540,687	157,037	2,697,724	5.00
6.00	00600	MAINTENANCE & REPAIRS	211,484	156,183	367,667	283	367,950	6.00
7.00	00700	OPERATION OF PLANT	0	346,094	346,094	19,827	365,921	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	123,998	123,998	0	123,998	8.00
9.00	00900	HOUSEKEEPING	234,065	48,625	282,690	3,010	285,700	9.00
10.00	01000	DIETARY	229,386	184,190	413,576	-334,759	78,817	10.00
11.00	01100	CAFETERIA	0	0	0	336,771	336,771	11.00
13.00	01300	NURSING ADMINISTRATION	583,291	48,712	632,003	197	632,200	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	143,831	68,653	212,484	235	212,719	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	759,130	230,367	989,497	267,331	1,256,828	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	623,750	155,261	779,011	10,264	789,275	50.00
53.00	05300	ANESTHESIOLOGY	0	60,854	60,854	-290	60,564	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	471,089	216,515	687,604	3,213	690,817	54.00
60.00	06000	LABORATORY	429,507	742,612	1,172,119	39,159	1,211,278	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	100,582	100,582	288	100,870	63.00
65.00	06500	RESPIRATORY THERAPY	253,912	103,540	357,452	-6,588	350,864	65.00
66.00	06600	PHYSICAL THERAPY	23,970	174,813	198,783	107	198,890	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,450	40,659	109,109	-73,303	35,806	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	192,531	688,288	880,819	333	881,152	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,044,051	333,027	2,377,078	-3,656	2,373,422	88.00
88.01	08801	RURAL HEALTH CLINIC II	271,736	913,015	1,184,751	-272,589	912,162	88.01
90.00	09000	CLINIC	186,217	204,595	390,812	120	390,932	90.00
91.00	09100	EMERGENCY	612,764	1,625,524	2,238,288	4,707	2,242,995	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		355,210	355,210	-355,210	0	113.00
114.00	11400	UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,542,361	9,804,751	18,347,112	2,144	18,349,256	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.02	07952	SPECIALTY CLINIC	299,455	29,404	328,859	-3,030	325,829	194.02
194.03	07953	PUBLIC RELATIONS	0	16,151	16,151	886	17,037	194.03
200.00		TOTAL (SUM OF LINES 118-199)	8,841,816	9,850,306	18,692,122	0	18,692,122	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/23/2015 9:56 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	260,026		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-173,818	265,098		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-8,747	1,043,912		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-20,769	2,676,955		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	367,950		6.00
7.00	00700	OPERATION OF PLANT	-93,448	272,473		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	123,998		8.00
9.00	00900	HOUSEKEEPING	0	285,700		9.00
10.00	01000	DIETARY	0	78,817		10.00
11.00	01100	CAFETERIA	-119,826	216,945		11.00
13.00	01300	NURSING ADMINISTRATION	0	632,200		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-11,043	201,676		16.00
17.00	01700	SOCIAL SERVICE	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-264,024	992,804		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-394,319	394,956		50.00
53.00	05300	ANESTHESIOLOGY	-56,231	4,333		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	690,817		54.00
60.00	06000	LABORATORY	-9,255	1,202,023		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	100,870		63.00
65.00	06500	RESPIRATORY THERAPY	-27,450	323,414		65.00
66.00	06600	PHYSICAL THERAPY	-12,450	186,440		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	35,806		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-8,618	872,534		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	2,373,422		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	912,162		88.01
90.00	09000	CLINIC	-115,782	275,150		90.00
91.00	09100	EMERGENCY	-391,667	1,851,328		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
114.00	11400	UTILIZATION REVIEW-SNF	0	0		114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-1,707,447	16,641,809		118.00
		NONREIMBURSABLE COST CENTERS				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0		194.00
194.02	07952	SPECIALTY CLINIC	0	325,829		194.02
194.03	07953	PUBLIC RELATIONS	0	17,037		194.03
200.00		TOTAL (SUM OF LINES 118-199)	-1,707,447	16,984,675		200.00

RECLASSIFICATIONS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/23/2015 9:56 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - TO RECLAS DIETARY COST				
1.00	CAFETERIA	11.00	186,787	149,984	1.00
	TOTALS		186,787	149,984	
	B - TO RECLASS INTEREST EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	99,308	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	255,902	2.00
	TOTALS		0	355,210	
	C - TO RECLASS PROPERTY INSURANCE				
1.00	OTHER CAP REL COSTS	3.00	0	75,624	1.00
	TOTALS		0	75,624	
	D - TO RECLASS HEALTH AND LIFE INSURANCE				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	29,890	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	29,890	
	E - TO RECLASS RURAL HEALTH CLINIC COST				
1.00	RURAL HEALTH CLINIC	88.00	2,983	228	1.00
	TOTALS		2,983	228	
	F - TO RECLASS TELEPHONE EXPENSE				
1.00	OPERATION OF PLANT	7.00	0	19,827	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	19,827	
	G - TO RECLASS OXYGEN EXPENSE				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	8,449	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	8,449	
	H - TO RECLASS HOSPITALIST				
1.00	ADULTS & PEDIATRICS	30.00	0	264,024	1.00
	TOTALS		0	264,024	
	I - TO RECLASS SUPPLIES				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	669	166	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	2,650	656	2.00
3.00	MAINTENANCE & REPAIRS	6.00	227	56	3.00
4.00	HOUSEKEEPING	9.00	2,413	597	4.00
5.00	DIETARY	10.00	1,613	399	5.00
6.00	NURSING ADMINISTRATION	13.00	158	39	6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	188	47	7.00
8.00	ADULTS & PEDIATRICS	30.00	2,651	656	8.00
9.00	OPERATING ROOM	50.00	8,228	2,036	9.00
10.00	ANESTHESIOLOGY	53.00	258	64	10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	2,576	637	11.00
12.00	LABORATORY	60.00	31,390	7,769	12.00
13.00	BLOOD STORING, PROCESSING, & TRANS.	63.00	231	57	13.00
14.00	RESPIRATORY THERAPY	65.00	1,001	248	14.00
15.00	PHYSICAL THERAPY	66.00	86	21	15.00
16.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	2,182	540	16.00
17.00	DRUGS CHARGED TO PATIENTS	73.00	267	66	17.00
18.00	RURAL HEALTH CLINIC	88.00	3,852	953	18.00
19.00	RURAL HEALTH CLINIC II	88.01	1,190	295	19.00
20.00	CLINIC	90.00	96	24	20.00
21.00	EMERGENCY	91.00	4,792	1,186	21.00
22.00	SPECIALTY CLINIC	194.02	287	71	22.00
23.00	PUBLIC RELATIONS	194.03	710	176	23.00
	TOTALS		67,715	16,759	
500.00	Grand Total: Increases		257,485	919,995	500.00

RECLASSIFICATIONS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/23/2015 9:56 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - TO RECLAS DIETARY COST						
1.00	DIETARY	10.00	186,787	149,984	0		1.00
	TOTALS		186,787	149,984			
	B - TO RECLASS INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	355,210	11		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	355,210			
	C - TO RECLASS PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	75,624	0		1.00
	TOTALS		0	75,624			
	D - TO RECLASS HEALTH AND LIFE INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	22,190	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	7,700	0		2.00
	TOTALS		0	29,890			
	E - TO RECLASS RURAL HEALTH CLINIC COST						
1.00	SPECIALTY CLINIC	194.02	2,983	228	0		1.00
	TOTALS		2,983	228			
	F - TO RECLASS TELEPHONE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,357	0		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	3,972	0		2.00
3.00	RURAL HEALTH CLINIC II	88.01	0	10,050	0		3.00
4.00	EMERGENCY	91.00	0	1,271	0		4.00
5.00	SPECIALTY CLINIC	194.02	0	177	0		5.00
	TOTALS		0	19,827			
	G - TO RECLASS OXYGEN EXPENSE						
1.00	ANESTHESIOLOGY	53.00	0	612	0		1.00
2.00	RESPIRATORY THERAPY	65.00	0	7,837	0		2.00
	TOTALS		0	8,449			
	H - TO RECLASS HOSPITALIST						
1.00	RURAL HEALTH CLINIC II	88.01	0	264,024	0		1.00
	TOTALS		0	264,024			
	I - TO RECLASS SUPPLIES						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	67,715	16,759	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
	TOTALS		67,715	16,759			
500.00	Grand Total: Decreases		257,485	919,995			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 11/23/2015 9:56 am

		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	18,401	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	9,477,441	0	0	0	0	3.00
4.00	Building Improvements	0	1,406,111	0	1,406,111	0	4.00
5.00	Fixed Equipment	6,970,152	0	0	0	0	5.00
6.00	Movable Equipment	0	0	0	0	0	6.00
7.00	HIT designated Assets	494,058	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	16,960,052	1,406,111	0	1,406,111	0	8.00
9.00	Reconciling Items	970,391	811,312	0	811,312	1,406,111	9.00
10.00	Total (line 8 minus line 9)	15,989,661	594,799	0	594,799	-1,406,111	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	18,401	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	9,477,441	0	3.00
4.00	Building Improvements	1,406,111	0	4.00
5.00	Fixed Equipment	6,970,152	0	5.00
6.00	Movable Equipment	0	0	6.00
7.00	HIT designated Assets	494,058	0	7.00
8.00	Subtotal (sum of lines 1-7)	18,366,163	0	8.00
9.00	Reconciling Items	375,592	0	9.00
10.00	Total (line 8 minus line 9)	17,990,571	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II | Date/Time Prepared: 11/23/2015 9:56 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	133,384	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	390,626	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	524,010	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	133,384		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	390,626		2.00
3.00	Total (sum of lines 1-2)	0	524,010		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 11/23/2015 9:56 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	4,680,012	1,540,774	3,139,238	0.361444	27,334	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5,546,036	0	5,546,036	0.638556	48,290	2.00
3.00	Total (sum of lines 1-2)	10,226,048	1,540,774	8,685,274	1.000000	75,624	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	27,334	133,384	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	48,290	216,808	0	2.00
3.00	Total (sum of lines 1-2)	0	0	75,624	350,192	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	99,308	27,334	0	0	260,026	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	48,290	0	0	265,098	2.00
3.00	Total (sum of lines 1-2)	99,308	75,624	0	0	525,124	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/23/2015 9:56 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-13,846	ADMINISTRATIVE & GENERAL	5.00	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	-1,251,427			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	-119,826	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-8,618	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-11,043	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	-12,450	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	UTILIZATION REVIEW-SNF	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-173,818	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00			0		0.00	0	33.00
33.01	NH UTILITIES	B	-87,952	OPERATION OF PLANT	7.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/23/2015 9:56 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	MISCELLANEOUS INCOME	B	-421	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	IHA LOBBYING DUES	A	-6,395	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	SURGEON BENEFIT OFFSET	A	-8,747	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05	SURGEON FICA OFFSET	A	-7,301	OPERATING ROOM	50.00	0	33.05
33.06	RADIO AND TV ADJUSTMENT	A	-2,446	OPERATION OF PLANT	7.00	0	33.06
33.07	TELEPHONE COST	A	-923	OPERATION OF PLANT	7.00	0	33.07
33.08	TELEPHONE COST	A	-2,127	OPERATION OF PLANT	7.00	0	33.08
33.09	INTEREST INCOME	B	-107	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10			0		0.00	0	33.10
33.11			0		0.00	0	33.11
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-1,707,447				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: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 11/23/2015 9:56 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	264,024	264,024	0	0	0	1.00
2.00	50.00	OPERATING ROOM	387,018	387,018	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	56,231	56,231	0	0	0	3.00
4.00	60.00	LABORATORY	9,255	9,255	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	27,450	27,450	0	0	0	5.00
6.00	90.00	CLINIC	115,782	115,782	0	0	0	6.00
7.00	91.00	EMERGENCY	1,439,000	391,667	1,047,333	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			2,298,760	1,251,427	1,047,333		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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	0	0	2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	91.00	EMERGENCY	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	264,024		1.00
2.00	50.00	OPERATING ROOM	0	0	0	387,018		2.00
3.00	53.00	ANESTHESIOLOGY	0	0	0	56,231		3.00
4.00	60.00	LABORATORY	0	0	0	9,255		4.00
5.00	65.00	RESPIRATORY THERAPY	0	0	0	27,450		5.00
6.00	90.00	CLINIC	0	0	0	115,782		6.00
7.00	91.00	EMERGENCY	0	0	0	391,667		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1,251,427		200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/23/2015 9:56 am

Physical Therapy — Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					201	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					315	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	304.47	1,431.15	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	78.94	59.20	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	39.47	39.47	29.60			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					24,035	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					84,724	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					108,759	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					108,759	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					108,759	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					7,933	24.00
25.00	Assistants (line 4 times column 3, line 11)					9,324	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					17,257	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					2,838	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					20,095	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					20,095	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/23/2015 9:56 am

Physical Therapy — Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	78.94	59.20	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00	Salary equivalency amount (from line 23)	108,759	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	20,095	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00
60.00	Overtime allowance (from column 5, line 56)	0	60.00
61.00	Equipment cost (see instructions)	0	61.00
62.00	Supplies (see instructions)	1,461	62.00
63.00	Total allowance (sum of lines 57-62)	130,315	63.00
64.00	Total cost of outside supplier services (from your records)	142,765	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	12,450	65.00
	LINE 33 CALCULATION		
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	17,257	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,838	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27	20,095	100.02
	LINE 34 CALCULATION		
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	2,838	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01
101.02	Line 34 = sum of lines 27 and 31	2,838	101.02
	LINE 35 CALCULATION		
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01
102.02	Line 35 = sum of lines 31 and 32	0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141321	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/23/2015 9:56 am

		Occupational Therapy	Cost	
			1.00	
	PART I - GENERAL INFORMATION			
1.00	Total number of weeks worked (excluding aides) (see instructions)		52	1.00
2.00	Line 1 multiplied by 15 hours per week		780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)		60	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)		101	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)		0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)		0	6.00
7.00	Standard travel expense rate		5.50	7.00
8.00	Optional travel expense rate per mile		0.00	8.00

		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	38.26	64.50	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	74.81	56.11	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	37.41	37.41	28.06			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01

		1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION		
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)	2,862	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)	3,619	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	6,481	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	6,481	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)	63.07	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)	49,195	22.00
23.00	Total salary equivalency (see instructions)	49,195	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
24.00	Therapists (line 3 times column 2, line 11)	2,245	24.00
25.00	Assistants (line 4 times column 3, line 11)	2,834	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	5,079	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)	886	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	5,965	28.00
	Optional Travel Allowance and Optional Travel Expense		
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)	5,965	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36.00
37.00	Assistants (line 6 times column 3, line 11)	0	37.00
38.00	Subtotal (sum of lines 36 and 37)	0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.		
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS	Provider CCN: 141321	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8-3 Parts I-VI Date/Time Prepared: 11/23/2015 9:56 am

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

		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	74.81	56.11	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

			1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)		49,195	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))		5,965	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)		0	59.00
60.00	Overtime allowance (from column 5, line 56)		0	60.00
61.00	Equipment cost (see instructions)		0	61.00
62.00	Supplies (see instructions)		133	62.00
63.00	Total allowance (sum of lines 57-62)		55,293	63.00
64.00	Total cost of outside supplier services (from your records)		12,975	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)		0	65.00
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others		5,079	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		886	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27		5,965	100.02
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		886	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	101.01
101.02	Line 34 = sum of lines 27 and 31		886	101.02
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		0	102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others		0	102.01
102.02	Line 35 = sum of lines 31 and 32		0	102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-3 Parts I-VI | Date/Time Prepared: 11/23/2015 9:56 am

Speech Pathology | Cost

						1.00	
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					218	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.50	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	205.84	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	71.89	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	35.95	35.95	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					14,798	15.00
16.00	Assistants (column 3, line 9 times column 3, line10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					14,798	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					14,798	20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.						
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					71.89	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					56,074	22.00
23.00	Total salary equivalency (see instructions)					56,074	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE						
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					7,837	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					7,837	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,199	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					9,036	28.00
	Optional Travel Allowance and Optional Travel Expense						
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					9,036	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE						
	Standard Travel Expense						
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
	Optional Travel Allowance and Optional Travel Expense						
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.						
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

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Speech Pathology | Cost

						1.00	
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions)	71.89	0.00	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00

		1.00		
	Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT			
57.00	Salary equivalency amount (from line 23)	56,074	57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))	9,036	58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59.00	
60.00	Overtime allowance (from column 5, line 56)	0	60.00	
61.00	Equipment cost (see instructions)	0	61.00	
62.00	Supplies (see instructions)	172	62.00	
63.00	Total allowance (sum of lines 57-62)	65,282	63.00	
64.00	Total cost of outside supplier services (from your records)	16,808	64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00	
	LINE 33 CALCULATION			
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	7,837	100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,199	100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27	9,036	100.02	
	LINE 34 CALCULATION			
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	1,199	101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101.01	
101.02	Line 34 = sum of lines 27 and 31	1,199	101.02	
	LINE 35 CALCULATION			
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0	102.01	
102.02	Line 35 = sum of lines 31 and 32	0	102.02	

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/23/2015 9:56 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	260,026	260,026				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	265,098		265,098			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,043,912	0	0	1,043,912		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,676,955	28,456	0	141,982	2,847,393	5.00
6.00	00600	MAINTENANCE & REPAIRS	367,950	10,149	0	26,344	404,443	6.00
7.00	00700	OPERATION OF PLANT	272,473	31,722	3,807	0	308,002	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	123,998	2,789	0	0	126,787	8.00
9.00	00900	HOUSEKEEPING	285,700	896	0	29,426	316,022	9.00
10.00	01000	DIETARY	78,817	18,443	0	5,501	102,761	10.00
11.00	01100	CAFETERIA	216,945	0	0	23,243	240,188	11.00
13.00	01300	NURSING ADMINISTRATION	632,200	2,000	0	72,601	706,801	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	201,676	3,910	8,748	17,921	232,255	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	992,804	23,889	44,454	94,791	1,155,938	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	394,956	24,865	35,475	30,481	485,777	50.00
53.00	05300	ANESTHESIOLOGY	4,333	384	0	32	4,749	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	690,817	10,269	139,935	58,940	899,961	54.00
60.00	06000	LABORATORY	1,202,023	7,296	8,879	57,380	1,275,578	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	100,870	0	0	0	100,870	63.00
65.00	06500	RESPIRATORY THERAPY	323,414	3,782	0	31,720	358,916	65.00
66.00	06600	PHYSICAL THERAPY	186,440	5,262	0	2,993	194,695	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	35,806	9,416	0	363	45,585	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	872,534	3,966	0	23,991	900,491	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,373,422	42,793	0	255,198	2,671,413	88.00
88.01	08801	RURAL HEALTH CLINIC II	912,162	5,642	11,911	33,961	963,676	88.01
90.00	09000	CLINIC	275,150	4,298	9,875	23,184	312,507	90.00
91.00	09100	EMERGENCY	1,851,328	9,488	2,014	76,845	1,939,675	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	16,641,809	249,715	265,098	1,006,897	16,594,483	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.02	07952	SPECIALTY CLINIC	325,829	10,311	0	36,927	373,067	194.02
194.03	07953	PUBLIC RELATIONS	17,037	0	0	88	17,125	194.03
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)	16,984,675	260,026	265,098	1,043,912	16,984,675	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/23/2015 9:56 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,847,393					5.00
6.00	00600	MAINTENANCE & REPAIRS	81,459	485,902				6.00
7.00	00700	OPERATION OF PLANT	62,035	69,614	439,651			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,536	6,120	6,464	164,907		8.00
9.00	00900	HOUSEKEEPING	63,650	1,965	2,075	0	383,712	9.00
10.00	01000	DIETARY	20,697	40,473	42,745	0	0	10.00
11.00	01100	CAFETERIA	48,376	0	0	0	15,016	11.00
13.00	01300	NURSING ADMINISTRATION	142,357	4,389	4,635	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	46,778	8,581	9,063	0	4,131	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	232,817	52,423	55,365	55,101	85,751	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	97,840	54,566	57,629	15,639	34,375	50.00
53.00	05300	ANESTHESIOLOGY	956	842	889	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	181,261	22,534	23,799	38,587	18,141	54.00
60.00	06000	LABORATORY	256,914	16,011	16,910	0	16,340	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	20,316	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	72,289	8,300	8,766	780	30,906	65.00
66.00	06600	PHYSICAL THERAPY	39,214	11,548	12,196	12,039	15,148	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,181	20,662	21,822	0	2,860	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	181,368	8,703	9,191	0	8,316	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	538,055	93,908	99,178	2,482	28,284	88.00
88.01	08801	RURAL HEALTH CLINIC II	194,094	12,381	13,075	0	50,344	88.01
90.00	09000	CLINIC	62,942	9,433	9,962	0	0	90.00
91.00	09100	EMERGENCY	390,670	20,821	21,990	39,186	45,498	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,768,805	463,274	415,754	163,814	355,110	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.02	07952	SPECIALTY CLINIC	75,139	22,628	23,897	1,093	28,602	194.02
194.03	07953	PUBLIC RELATIONS	3,449	0	0	0	0	194.03
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)	2,847,393	485,902	439,651	164,907	383,712	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/23/2015 9:56 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	206,676					10.00
11.00	01100	CAFETERIA	0	303,580				11.00
13.00	01300	NURSING ADMINISTRATION	0	24,420	882,602			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	12,225	88,938	401,971		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	206,676	47,705	347,069	16,736	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,815	107,784	21,988	0	50.00
53.00	05300	ANESTHESIOLOGY	0	29	0	702	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	25,992	0	93,806	0	54.00
60.00	06000	LABORATORY	0	29,136	0	88,485	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	12,341	0	22,938	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,678	0	9,309	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	175	0	3,887	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,044	51,245	33,623	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	78,617	0	26,789	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	7,349	0	88.01
90.00	09000	CLINIC	0	11,002	80,044	12,797	0	90.00
91.00	09100	EMERGENCY	0	28,524	207,522	61,858	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	206,676	294,703	882,602	400,267	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.02	07952	SPECIALTY CLINIC	0	8,877	0	1,704	0	194.02
194.03	07953	PUBLIC RELATIONS	0	0	0	0	0	194.03
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)	206,676	303,580	882,602	401,971	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/23/2015 9:56 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,255,581	0	2,255,581		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	890,413	0	890,413		50.00
53.00	05300	ANESTHESIOLOGY	0	8,167	0	8,167		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,304,081	0	1,304,081		54.00
60.00	06000	LABORATORY	0	1,699,374	0	1,699,374		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	121,186	0	121,186		63.00
65.00	06500	RESPIRATORY THERAPY	0	515,236	0	515,236		65.00
66.00	06600	PHYSICAL THERAPY	0	296,827	0	296,827		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	104,172	0	104,172		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,199,981	0	1,199,981		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	3,538,726	0	3,538,726		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1,240,919	0	1,240,919		88.01
90.00	09000	CLINIC	0	498,687	0	498,687		90.00
91.00	09100	EMERGENCY	0	2,755,744	0	2,755,744		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	16,429,094	0	16,429,094		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0		194.00
194.02	07952	SPECIALTY CLINIC	0	535,007	0	535,007		194.02
194.03	07953	PUBLIC RELATIONS	0	20,574	0	20,574		194.03
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	16,984,675	0	16,984,675		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/23/2015 9:56 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	28,456	0	28,456	0	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	10,149	0	10,149	0	6.00
7.00	00700	OPERATION OF PLANT	0	31,722	3,807	35,529	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,789	0	2,789	0	8.00
9.00	00900	HOUSEKEEPING	0	896	0	896	0	9.00
10.00	01000	DIETARY	0	18,443	0	18,443	0	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	2,000	0	2,000	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,910	8,748	12,658	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	23,889	44,454	68,343	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	24,865	35,475	60,340	0	50.00
53.00	05300	ANESTHESIOLOGY	0	384	0	384	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	10,269	139,935	150,204	0	54.00
60.00	06000	LABORATORY	0	7,296	8,879	16,175	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,782	0	3,782	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5,262	0	5,262	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,416	0	9,416	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,966	0	3,966	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	42,793	0	42,793	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	5,642	11,911	17,553	0	88.01
90.00	09000	CLINIC	0	4,298	9,875	14,173	0	90.00
91.00	09100	EMERGENCY	0	9,488	2,014	11,502	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	249,715	265,098	514,813	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.02	07952	SPECIALTY CLINIC	0	10,311	0	10,311	0	194.02
194.03	07953	PUBLIC RELATIONS	0	0	0	0	0	194.03
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	260,026	265,098	525,124	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/23/2015 9:56 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	28,456					5.00
6.00	00600	MAINTENANCE & REPAIRS	814	10,963				6.00
7.00	00700	OPERATION OF PLANT	620	1,571	37,720			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	255	138	555	3,737		8.00
9.00	00900	HOUSEKEEPING	636	44	178	0	1,754	9.00
10.00	01000	DIETARY	207	913	3,667	0	0	10.00
11.00	01100	CAFETERIA	483	0	0	0	69	11.00
13.00	01300	NURSING ADMINISTRATION	1,423	99	398	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	468	194	778	0	19	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,327	1,183	4,750	1,249	392	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	978	1,231	4,944	354	157	50.00
53.00	05300	ANESTHESIOLOGY	10	19	76	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,812	508	2,042	874	83	54.00
60.00	06000	LABORATORY	2,568	361	1,451	0	75	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	203	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	722	187	752	18	141	65.00
66.00	06600	PHYSICAL THERAPY	392	261	1,046	273	69	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	92	466	1,872	0	13	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,813	196	789	0	38	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,374	2,119	8,508	56	129	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,940	279	1,122	0	230	88.01
90.00	09000	CLINIC	629	213	855	0	0	90.00
91.00	09100	EMERGENCY	3,905	470	1,887	888	208	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	27,671	10,452	35,670	3,712	1,623	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.02	07952	SPECIALTY CLINIC	751	511	2,050	25	131	194.02
194.03	07953	PUBLIC RELATIONS	34	0	0	0	0	194.03
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)	28,456	10,963	37,720	3,737	1,754	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/23/2015 9:56 am

		Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	23,230					10.00
11.00	01100	CAFETERIA	0	552				11.00
13.00	01300	NURSING ADMINISTRATION	0	44	3,964			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22	399	14,538		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,230	87	1,560	605	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	27	484	795	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	25	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	47	0	3,392	0	54.00
60.00	06000	LABORATORY	0	53	0	3,200	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	22	0	830	0	65.00
66.00	06600	PHYSICAL THERAPY	0	5	0	337	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	141	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13	230	1,216	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	144	0	969	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	266	0	88.01
90.00	09000	CLINIC	0	20	359	463	0	90.00
91.00	09100	EMERGENCY	0	52	932	2,237	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	23,230	536	3,964	14,476	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.02	07952	SPECIALTY CLINIC	0	16	0	62	0	194.02
194.03	07953	PUBLIC RELATIONS	0	0	0	0	0	194.03
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)	23,230	552	3,964	14,538	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/23/2015 9:56 am

		Cost Center Description	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			19.00	24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		103,726	0	103,726		30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		69,310	0	69,310		50.00
53.00	05300	ANESTHESIOLOGY		514	0	514		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		158,962	0	158,962		54.00
60.00	06000	LABORATORY		23,883	0	23,883		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.		203	0	203		63.00
65.00	06500	RESPIRATORY THERAPY		6,454	0	6,454		65.00
66.00	06600	PHYSICAL THERAPY		7,645	0	7,645		66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		12,000	0	12,000		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS		8,261	0	8,261		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC		60,092	0	60,092		88.00
88.01	08801	RURAL HEALTH CLINIC II		21,390	0	21,390		88.01
90.00	09000	CLINIC		16,712	0	16,712		90.00
91.00	09100	EMERGENCY		22,081	0	22,081		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	511,233	0	511,233		118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES		0	0	0		192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER		0	0	0		194.00
194.02	07952	SPECIALTY CLINIC		13,857	0	13,857		194.02
194.03	07953	PUBLIC RELATIONS		34	0	34		194.03
200.00		Cross Foot Adjustments	0	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	0	525,124	0	525,124		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/23/2015 9:56 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	60,977					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		179,148				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	8,389,304			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	6,673	0	1,141,022	-2,847,393	14,137,282	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,380	0	211,711	0	404,443	6.00
7.00	00700	OPERATION OF PLANT	7,439	2,573	0	0	308,002	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	654	0	0	0	126,787	8.00
9.00	00900	HOUSEKEEPING	210	0	236,478	0	316,022	9.00
10.00	01000	DIETARY	4,325	0	44,212	0	102,761	10.00
11.00	01100	CAFETERIA	0	0	186,787	0	240,188	11.00
13.00	01300	NURSING ADMINISTRATION	469	0	583,449	0	706,801	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	917	5,912	144,019	0	232,255	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,602	30,041	761,781	0	1,155,938	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,831	23,973	244,961	0	485,777	50.00
53.00	05300	ANESTHESIOLOGY	90	0	258	0	4,749	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,408	94,566	473,665	0	899,961	54.00
60.00	06000	LABORATORY	1,711	6,000	461,128	0	1,275,578	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	100,870	63.00
65.00	06500	RESPIRATORY THERAPY	887	0	254,913	0	358,916	65.00
66.00	06600	PHYSICAL THERAPY	1,234	0	24,056	0	194,695	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,208	0	2,916	0	45,585	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	930	0	192,798	0	900,491	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,035	0	2,050,886	0	2,671,413	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,323	8,049	272,926	0	963,676	88.01
90.00	09000	CLINIC	1,008	6,673	186,313	0	312,507	90.00
91.00	09100	EMERGENCY	2,225	1,361	617,556	0	1,939,675	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,559	179,148	8,091,835	-2,847,393	13,747,090	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.02	07952	SPECIALTY CLINIC	2,418	0	296,759	0	373,067	194.02
194.03	07953	PUBLIC RELATIONS	0	0	710	0	17,125	194.03
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)	260,026	265,098	1,043,912		2,847,393	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.264329	1.479771	0.124434		0.201410	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0		28,456	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000		0.002013	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/23/2015 9:56 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	51,924					6.00
7.00	00700	OPERATION OF PLANT	7,439	44,485				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	654	654	61,117			8.00
9.00	00900	HOUSEKEEPING	210	210	0	14,489		9.00
10.00	01000	DIETARY	4,325	4,325	0	0	5,816	10.00
11.00	01100	CAFETERIA	0	0	0	567	0	11.00
13.00	01300	NURSING ADMINISTRATION	469	469	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	917	917	0	156	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,602	5,602	20,421	3,238	5,816	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,831	5,831	5,796	1,298	0	50.00
53.00	05300	ANESTHESIOLOGY	90	90	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,408	2,408	14,301	685	0	54.00
60.00	06000	LABORATORY	1,711	1,711	0	617	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	887	887	289	1,167	0	65.00
66.00	06600	PHYSICAL THERAPY	1,234	1,234	4,462	572	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,208	2,208	0	108	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	930	930	0	314	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	10,035	10,035	920	1,068	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,323	1,323	0	1,901	0	88.01
90.00	09000	CLINIC	1,008	1,008	0	0	0	90.00
91.00	09100	EMERGENCY	2,225	2,225	14,523	1,718	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	49,506	42,067	60,712	13,409	5,816	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.02	07952	SPECIALTY CLINIC	2,418	2,418	405	1,080	0	194.02
194.03	07953	PUBLIC RELATIONS	0	0	0	0	0	194.03
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)	485,902	439,651	164,907	383,712	206,676	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	9.357946	9.883129	2.698218	26.482987	35.535763	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,963	37,720	3,737	1,754	23,230	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.211136	0.847926	0.061145	0.121057	3.994154	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/23/2015 9:56 am

		Cost Center Description	CAFETERIA (FTE)	NURSING ADMINISTRATION (DIRECT NUR S. HRS. FT)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	10,430					11.00
13.00	01300	NURSING ADMINISTRATION	839	4,168				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	420	420	41,658,231			16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,639	1,639	1,734,469	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	509	509	2,278,785	0	0	50.00
53.00	05300	ANESTHESIOLOGY	1	0	72,774	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	893	0	9,720,535	0	0	54.00
60.00	06000	LABORATORY	1,001	0	9,170,402	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	424	0	2,377,281	0	0	65.00
66.00	06600	PHYSICAL THERAPY	92	0	964,815	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6	0	402,852	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	242	242	3,484,616	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,701	0	2,776,379	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	761,649	0	0	88.01
90.00	09000	CLINIC	378	378	1,326,257	0	0	90.00
91.00	09100	EMERGENCY	980	980	6,410,788	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,125	4,168	41,481,602	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
194.00	07950	OTHER NONREIMBURSABLE COST CENTER	0	0	0	0	0	194.00
194.02	07952	SPECIALTY CLINIC	305	0	176,629	0	0	194.02
194.03	07953	PUBLIC RELATIONS	0	0	0	0	0	194.03
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)	303,580	882,602	401,971	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	29.106424	211.756718	0.009649	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	552	3,964	14,538	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.052924	0.951056	0.000349	0.000000	0.000000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,255,581		2,255,581	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	890,413		890,413	0	0	50.00
53.00	05300	ANESTHESIOLOGY	8,167		8,167	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,304,081		1,304,081	0	0	54.00
60.00	06000	LABORATORY	1,699,374		1,699,374	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	121,186		121,186	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	515,236	0	515,236	0	0	65.00
66.00	06600	PHYSICAL THERAPY	296,827	0	296,827	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	104,172		104,172	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,199,981		1,199,981	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,538,726		3,538,726	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	1,240,919		1,240,919	0	0	88.01
90.00	09000	CLINIC	498,687		498,687	0	0	90.00
91.00	09100	EMERGENCY	2,755,744		2,755,744	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	129,108		129,108		0	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	16,558,202	0	16,558,202	0	0	200.00
201.00		Less Observation Beds	129,108		129,108		0	201.00
202.00		Total (see instructions)	16,429,094	0	16,429,094	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,734,469		1,734,469			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,095	1,864,217	1,883,312	0.472791	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	2,457	70,317	72,774	0.112224	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,120,927	8,599,608	9,720,535	0.134157	0.000000	54.00
60.00	06000	LABORATORY	947,214	7,988,924	8,936,138	0.190169	0.000000	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	70,946	163,318	234,264	0.517305	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	536,595	1,752,125	2,288,720	0.225120	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	239,691	725,124	964,815	0.307652	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0.000000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	261,647	141,205	402,852	0.258586	0.000000	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,032,586	2,452,030	3,484,616	0.344365	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	483	2,756,874	2,757,357			88.00
88.01	08801	RURAL HEALTH CLINIC II	21,627	454,248	475,875			88.01
90.00	09000	CLINIC	0	1,326,257	1,326,257	0.376011	0.000000	90.00
91.00	09100	EMERGENCY	160,508	4,850,861	5,011,369	0.549898	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	14,501	92,310	106,811	1.208752	0.000000	92.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
200.00		Subtotal (see instructions)	6,162,746	33,237,418	39,400,164			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	6,162,746	33,237,418	39,400,164			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		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
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
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
90.00	09000	CLINIC	0.000000		90.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
114.00	11400	UTILIZATION REVIEW-SNF			114.00
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: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	69,310	1,883,312	0.036802	3,769	139	50.00
53.00	05300	ANESTHESIOLOGY	514	72,774	0.007063	683	5	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	158,962	9,720,535	0.016353	579,256	9,473	54.00
60.00	06000	LABORATORY	23,883	8,936,138	0.002673	544,837	1,456	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	203	234,264	0.000867	64,332	56	63.00
65.00	06500	RESPIRATORY THERAPY	6,454	2,288,720	0.002820	352,449	994	65.00
66.00	06600	PHYSICAL THERAPY	7,645	964,815	0.007924	117,331	930	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,000	402,852	0.029788	167,669	4,995	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,261	3,484,616	0.002371	621,286	1,473	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	60,092	2,757,357	0.021793	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	21,390	475,875	0.044949	0	0	88.01
90.00	09000	CLINIC	16,712	1,326,257	0.012601	0	0	90.00
91.00	09100	EMERGENCY	22,081	5,011,369	0.004406	2,023	9	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,561	106,811	0.061426	0	0	92.00
200.00		Total (lines 50-199)	414,068	37,665,695		2,453,635	19,530	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
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
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
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
90.00	09000	CLINIC	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,883,312	0.000000	0.000000	3,769	50.00
53.00	05300	ANESTHESIOLOGY	0	72,774	0.000000	0.000000	683	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	9,720,535	0.000000	0.000000	579,256	54.00
60.00	06000	LABORATORY	0	8,936,138	0.000000	0.000000	544,837	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	234,264	0.000000	0.000000	64,332	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,288,720	0.000000	0.000000	352,449	65.00
66.00	06600	PHYSICAL THERAPY	0	964,815	0.000000	0.000000	117,331	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	402,852	0.000000	0.000000	167,669	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,484,616	0.000000	0.000000	621,286	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,757,357	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	475,875	0.000000	0.000000	0	88.01
90.00	09000	CLINIC	0	1,326,257	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	5,011,369	0.000000	0.000000	2,023	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	106,811	0.000000	0.000000	0	92.00
200.00		Total (lines 50-199)	0	37,665,695			2,453,635	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
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
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
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
90.00	09000	CLINIC	0	0	0		90.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.472791	0	955,427	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.112224	0	28,392	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.134157	0	2,885,559	0	0	54.00
60.00	06000	LABORATORY	0.190169	0	2,711,085	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.517305	0	129,396	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.225120	0	817,273	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.307652	0	254,085	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.258586	0	60,352	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.344365	0	1,293,607	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
90.00	09000	CLINIC	0.376011	0	1,108,773	0	0	90.00
91.00	09100	EMERGENCY	0.549898	0	1,375,933	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.208752	0	36,430	0	0	92.00
200.00		Subtotal (see instructions)		0	11,656,312	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	11,656,312	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	451,717	0		50.00
53.00	05300	ANESTHESIOLOGY	3,186	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	387,118	0		54.00
60.00	06000	LABORATORY	515,564	0		60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	66,937	0		63.00
65.00	06500	RESPIRATORY THERAPY	183,984	0		65.00
66.00	06600	PHYSICAL THERAPY	78,170	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,606	0		71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	445,473	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
90.00	09000	CLINIC	416,911	0		90.00
91.00	09100	EMERGENCY	756,623	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	44,035	0		92.00
200.00		Subtotal (see instructions)	3,365,324	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	3,365,324	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141321 | Component CCN: 14Z321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.472791	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.112224	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.134157	0	0	0	0	54.00
60.00	06000	LABORATORY	0.190169	0	0	0	0	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.517305	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.225120	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.307652	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.258586	0	0	0	0	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.344365	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
90.00	09000	CLINIC	0.376011	0	0	0	0	90.00
91.00	09100	EMERGENCY	0.549898	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.208752	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: 141321 | Component CCN: 14Z321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
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
90.00	09000	CLINIC	0	0		90.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1,583	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,407	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)	1,318	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	72	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)	73	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	19	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)	12	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	885	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)	72	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)	24	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,255,581	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	2,556	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	1,614	25.00
26.00	Total swing-bed cost (see instructions)	214,514	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,041,067	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,041,067	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)	1,450.65	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,283,825	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)	1,283,825	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						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)	590,318	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,874,143	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)	104,447	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	34,816	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	139,263	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)	89	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,450.65	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	129,108	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	103,726	2,041,067	0.050819	129,108	6,561	90.00
91.00	Nursing School cost	0	2,041,067	0.000000	129,108	0	91.00
92.00	Allied health cost	0	2,041,067	0.000000	129,108	0	92.00
93.00	All other Medical Education	0	2,041,067	0.000000	129,108	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,099,087		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.472791	3,769	1,782	50.00
53.00	05300	ANESTHESIOLOGY	0.112224	683	77	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.134157	579,256	77,711	54.00
60.00	06000	LABORATORY	0.190169	544,837	103,611	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.517305	64,332	33,279	63.00
65.00	06500	RESPIRATORY THERAPY	0.225120	352,449	79,343	65.00
66.00	06600	PHYSICAL THERAPY	0.307652	117,331	36,097	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.258586	167,669	43,357	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.344365	621,286	213,949	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
90.00	09000	CLINIC	0.376011	0	0	90.00
91.00	09100	EMERGENCY	0.549898	2,023	1,112	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.208752	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		2,453,635	590,318	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)		2,453,635		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141321 | Component CCN: 14Z321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.472791	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.112224	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.134157	11,427	1,533	54.00
60.00	06000	LABORATORY	0.190169	35,629	6,776	60.00
63.00	06300	BLOOD STORING, PROCESSING, & TRANS.	0.517305	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.225120	17,001	3,827	65.00
66.00	06600	PHYSICAL THERAPY	0.307652	47,374	14,575	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.258586	12,493	3,231	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.344365	72,713	25,040	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
90.00	09000	CLINIC	0.376011	0	0	90.00
91.00	09100	EMERGENCY	0.549898	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1.208752	0	0	92.00
200.00		Total (sum of lines 50-94 and 96-98)		196,637	54,982	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)		196,637		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141321	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 11/23/2015 9:56 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	3,365,324	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	3,365,324	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)	3,398,977	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)	17,943	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,776,495	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)	1,604,539	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)	1,604,539	30.00
31.00	Primary payer payments	217	31.00
32.00	Subtotal (line 30 minus line 31)	1,604,322	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)	409,955	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	311,566	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	312,726	36.00
37.00	Subtotal (see instructions)	1,915,888	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)	1,915,888	40.00
40.01	Sequestration adjustment (see instructions)	38,318	40.01
41.00	Interim payments	2,095,622	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-218,052	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: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,951,364		2,811,824	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	02/26/2015	51,323		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	06/18/2015	150,562	02/26/2015	150,609	3.50
3.51			0	06/18/2015	565,593	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)		-99,239		-716,202	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,852,125		2,095,622	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		149,593		218,052	6.02
7.00	Total Medicare program liability (see instructions)		1,702,532		1,877,570	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: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/23/2015 9:56 am

Component CCN: 14Z321 | 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		216,189		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	02/26/2015	7,930		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	06/18/2015	21,829		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-13,899		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)		202,290		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		14,587		0	6.02
7.00	Total Medicare program liability (see instructions)		187,703		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: 141321	Period: From 07/01/2014 To 06/30/2015	Worksheet E-1 Part II Date/Time Prepared: 11/23/2015 9:56 am
	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	485	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	885	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	1,318	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	39,400,164	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	182,337	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141321 | Component CCN: 14Z321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-2 | Date/Time Prepared: 11/23/2015 9:56 am

Title XVIII | Swing Beds - SNF | Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	140,656	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)	55,532	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	96	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)	196,188	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	196,188	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)	196,188	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	4,654	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)	191,534	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)	191,534	0	19.00
19.01	Sequestration adjustment (see instructions)	3,831	0	19.01
20.00	Interim payments	202,290	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)	-14,587	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: 141321	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part V Date/Time Prepared: 11/23/2015 9:56 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	1,874,143	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	1,874,143	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	1,892,884	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	1,892,884	19.00
20.00	Deductibles (exclude professional component)	196,324	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	1,696,560	22.00
23.00	Coinsurance	2,205	23.00
24.00	Subtotal (line 22 minus line 23)	1,694,355	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	56,478	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	42,923	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	50,457	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	1,737,278	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	29.50
29.99	Recovery of Accelerated Depreciation	0	29.99
30.00	Subtotal (see instructions)	1,737,278	30.00
30.01	Sequestration adjustment (see instructions)	34,746	30.01
31.00	Interim payments	1,852,125	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)	-149,593	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/23/2015 9:56 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	9,702	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	5,171,846	0	0	0	4.00
5.00	Other receivable	716,488	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	219,737	0	0	0	7.00
8.00	Prepaid expenses	144,955	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	6,262,728	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	393,993	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	9,477,441	0	0	0	15.00
16.00	Accumulated depreciation	-8,760,114	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	8,870,321	0	0	0	23.00
24.00	Accumulated depreciation	-6,597,055	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)	3,384,586	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	0	0	0	0	33.00
34.00	Other assets	1,977,430	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1,977,430	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	11,624,744	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	2,627,955	0	0	0	37.00
38.00	Salaries, wages, and fees payable	840,895	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	3,789,652	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	7,258,502	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,483,670	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	782,787	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	3,266,457	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	10,524,959	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	1,099,785				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)	1,099,785	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	11,624,744	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/23/2015 9:56 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		655,455		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		444,330				2.00
3.00	Total (sum of line 1 and line 2)		1,099,785		0		3.00
4.00	ROUNDING	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		1,099,785		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)		1,099,785		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	ROUNDING		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: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/23/2015 9:56 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	1,841,279		1,841,279	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1,841,279		1,841,279	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)	1,841,279		1,841,279	17.00
18.00	Ancillary services	4,250,715	24,221,344	28,472,059	18.00
19.00	Outpatient services	180,963	7,556,082	7,737,045	19.00
20.00	RURAL HEALTH CLINIC	1,763	2,774,616	2,776,379	20.00
20.01	RURAL HEALTH CLINIC II	267,642	494,007	761,649	20.01
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	PROFESSIONAL FEES	0	232,263	232,263	27.00
27.01	SENIOR CARE	0	0	0	27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	6,542,362	35,278,312	41,820,674	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		18,692,122		29.00
30.00	BAD DEBT	1,917,099			30.00
31.00	EMPLOYEE W COMP	6,803			31.00
32.00	EMP HEALTH ALLOWANCE	6,913			32.00
33.00	INDUST BILLG DISC	396,614			33.00
34.00	CHARITY CARE	209,524			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		2,536,953		36.00
37.00	INTEREST	355,210			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)		355,210		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		20,873,865		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141321 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-3 | Date/Time Prepared: 11/23/2015 9:56 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	41,820,674	1.00
2.00	Less contractual allowances and discounts on patients' accounts	22,725,043	2.00
3.00	Net patient revenues (line 1 minus line 2)	19,095,631	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	20,873,865	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,778,234	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	MISCELLANEOUS INCOME	1,269,804	24.00
24.01	GRANT INCOME	80,746	24.01
24.02	OTHER INTEREST INCOME	40,045	24.02
24.03	PROPERTY TAX INCOME	706,628	24.03
24.04	REPLACEMENT TAX INCOME	125,846	24.04
24.05	ROUNDING	0	24.05
25.00	Total other income (sum of lines 6-24)	2,223,069	25.00
26.00	Total (line 5 plus line 25)	444,835	26.00
27.00	ROUNDING	505	27.00
27.01		0	27.01
27.02		0	27.02
27.03		0	27.03
28.00	Total other expenses (sum of line 27 and subscripts)	505	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	444,330	29.00

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

Provider CCN: 141321 Component CCN: 143469 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/23/2015 9:56 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	759,284	0	759,284	0	759,284	1.00
2.00	Physician Assistant	173,930	0	173,930	0	173,930	2.00
3.00	Nurse Practitioner	337,518	0	337,518	0	337,518	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	411,964	0	411,964	0	411,964	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,682,696	0	1,682,696	0	1,682,696	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	24,989	24,989	0	24,989	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	14,685	14,685	0	14,685	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	39,674	39,674	0	39,674	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,682,696	39,674	1,722,370	0	1,722,370	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	65,792	65,792	0	65,792	29.00
30.00	Administrative Costs	361,355	227,561	588,916	-3,656	585,260	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	361,355	293,353	654,708	-3,656	651,052	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	2,044,051	333,027	2,377,078	-3,656	2,373,422	32.00

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

Provider CCN: 141321 | Component CCN: 143469 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/23/2015 9:56 am

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	759,284		1.00
2.00	Physician Assistant	0	173,930		2.00
3.00	Nurse Practitioner	0	337,518		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	411,964		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	1,682,696		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	24,989		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	14,685		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	39,674		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	1,722,370		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	65,792		29.00
30.00	Administrative Costs	0	585,260		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	651,052		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	2,373,422		32.00

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

Provider CCN: 141321 Component CCN: 148510 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/23/2015 9:56 am

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	2,430	818,964	821,394	-264,024	557,370	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	76,075	0	76,075	0	76,075	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	101,939	0	101,939	0	101,939	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	180,444	818,964	999,408	-264,024	735,384	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	13,438	13,438	0	13,438	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	881	881	0	881	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,319	14,319	0	14,319	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	180,444	833,283	1,013,727	-264,024	749,703	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	28,600	28,600	0	28,600	29.00
30.00	Administrative Costs	91,293	51,131	142,424	-8,565	133,859	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	91,293	79,731	171,024	-8,565	162,459	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	271,737	913,014	1,184,751	-272,589	912,162	32.00

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

Provider CCN: 141321 | Component CCN: 148510 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/23/2015 9:56 am

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	557,370		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	76,075		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	101,939		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	735,384		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	13,438		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	881		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	14,319		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	749,703		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	28,600		29.00
30.00	Administrative Costs	0	133,859		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	162,459		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	912,162		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141321 Component CCN: 143469 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-2 | Date/Time Prepared: 11/23/2015 9:56 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	2.19	11,188	4,200	9,198		1.00
2.00	Physician Assistant	1.33	3,354	2,100	2,793		2.00
3.00	Nurse Practitioner	2.08	5,491	2,100	4,368		3.00
4.00	Subtotal (sum of lines 1 through 3)	5.60	20,033		16,359	20,033	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.60	20,033			20,033	8.00
9.00	Physician Services Under Agreements		0			0	9.00

		1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES		
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)	1,722,370	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	1,722,370	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)	651,052	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	1,165,304	15.00
16.00	Total overhead (sum of lines 14 and 15)	1,816,356	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	1,816,356	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	1,816,356	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	3,538,726	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141321 | Component CCN: 148510 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-2 | Date/Time Prepared: 11/23/2015 9:56 am

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	0.22	1,451	4,200	924		1.00
2.00	Physician Assistant	0.75	1,431	2,100	1,575		2.00
3.00	Nurse Practitioner	0.44	685	2,100	924		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.41	3,567		3,423	3,567	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)	1.41	3,567			3,567	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)	749,703	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)	0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)	749,703	12.00
13.00	Ratio of RHC/FQHC services (line 10 divided by line 12)	1.000000	13.00
14.00	Total facility overhead - (from Wkst. M-1, col. 7, line 31)	162,459	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	328,757	15.00
16.00	Total overhead (sum of lines 14 and 15)	491,216	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	491,216	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	491,216	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	1,240,919	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141321 Component CCN: 143469	Period: From 07/01/2014 To 06/30/2015	Worksheet M-3 Date/Time Prepared: 11/23/2015 9:56 am
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		3,538,726	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		19,743	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		3,518,983	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		20,033	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)		20,033	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		175.66	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	175.66	175.66	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	8,414	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	1,478,003	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) *		1,478,003	16.00
16.01	Total program charges (see instructions)(from contractor's records)		1,232,590	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		6,559	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		7,864	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		1,112,453	16.04
16.05	Total program cost (see instructions)		1,120,317	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		79,573	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		229,292	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		1,120,317	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,956	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		1,134,273	22.00
23.00	Allowable bad debts (see instructions)		102,453	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		77,864	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		95,132	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)		1,212,137	26.00
26.01	Sequestration adjustment (see instructions)		24,243	26.01
27.00	Interim payments		1,076,750	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)		111,144	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: 141321 Component CCN: 148510	Period: From 07/01/2014 To 06/30/2015	Worksheet M-3 Date/Time Prepared: 11/23/2015 9:56 am
	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)		1,240,919	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		1,240,919	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,567	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)		3,567	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		347.89	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	347.89	347.89	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,193	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	415,033	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) *		415,033	16.00
16.01	Total program charges (see instructions)(from contractor's records)		166,540	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		633	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		1,578	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.)		320,661	16.04
16.05	Total program cost (see instructions)		322,239	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		12,629	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		30,656	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		322,239	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		322,239	22.00
23.00	Allowable bad debts (see instructions)		13,640	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		10,366	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		13,115	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)		332,605	26.00
26.01	Sequestration adjustment (see instructions)		6,652	26.01
27.00	Interim payments		198,890	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)		127,063	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: 141321 | Component CCN: 143469 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-4 | Date/Time Prepared: 11/23/2015 9:56 am

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)	1,682,696	1,682,696	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000266	0.000488	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	448	821	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,269	7,071	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,717	7,892	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,722,370	1,722,370	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	1,816,356	1,816,356	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.000997	0.004582	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,811	8,323	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,528	16,215	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	43	79	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	82.05	205.25	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	35	54	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	2,872	11,084	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)		19,743	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)		13,956	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141321 Component CCN: 143469	Period: From 07/01/2014 To 06/30/2015	Worksheet M-5 Date/Time Prepared: 11/23/2015 9:56 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		1,031,947	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		02/26/2015	58,596	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		06/18/2015	13,793	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)		44,803	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		1,076,750	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		111,144	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		1,187,894	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: 141321 Component CCN: 148510	Period: From 07/01/2014 To 06/30/2015	Worksheet M-5 Date/Time Prepared: 11/23/2015 9:56 am
		Rural Health Clinic (RHC) II	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		200,542	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		06/18/2015	16,855	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		02/26/2015	18,507	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)		-1,652	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		198,890	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		127,063	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		325,953	7.00

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