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: 141323	Period: From 04/01/2014 To 03/31/2015	Worksheet S Parts I-III Date/Time Prepared: 8/31/2015 3:43 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 8/31/2015 Time: 3:43 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MASSAC MEMORIAL HOSPITAL (141323) for the cost reporting period beginning 04/01/2014 and ending 03/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-454,940	617,122	490,673	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	369,460	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		18,329		0	10.00
200.00	Total	0	-85,480	635,451	490,673	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2015 3:42 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 28 CHICK STREET	PO Box:			1.00
2.00	City: METROPOLIS	State: IL	Zip Code: 62960-	County: MASSAC	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	MASSAC MEMORIAL HOSPITAL	141323	99916	1	02/03/2003	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	MASSAC MEMORIAL HOSPITAL	14Z323	99916		02/03/2003	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	MASSAC MEMORIAL MEDICAL CLINIC	143478	99916		02/07/2006	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	04/01/2014	03/31/2015	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 8/31/2015 3:42 pm

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for 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, § 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: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2015 3:42 pm

		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: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 8/31/2015 3:42 pm

		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, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (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, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (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

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		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: 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 would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00

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

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

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	370,221	0	0	118.01

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

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		1.00	2.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N		140.00

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

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no.	N	145.00

		1.00	2.00	
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, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
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 Section §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)	500,687	168.00
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141323	Period: From 04/01/2014 To 03/31/2015	Worksheet S-2 Part I Date/Time Prepared: 8/31/2015 3:42 pm

		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)	10/01/2013	09/30/2014	170.00
			1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)		N	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 8/31/2015 3:42 pm

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/30/2013	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 Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N		9.00
10.00	Was an Intern-Resident program been 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	08/17/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 8/31/2015 3:42 pm

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	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.	KYLE	LEE	41.00
42.00	Enter the employer/company name of the cost report preparer.	MEDTRACK, INC		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	417-268-5953	KYLE.LEE@EDPTS.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 8/31/2015 3:42 pm

		Part B Date 4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	08/17/2015			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.		PRIN		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: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 8/31/2015 3:42 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	53,119.00	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	53,119.00	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	53,119.00	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
26.25	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: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2015 3:42 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,840	283	2,339			1.00
2.00	HMO and other (see instructions)	188	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	399	0	399			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		85	85			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,239	368	2,823			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)	2,239	368	2,823	0.00	173.79	14.00
15.00	CAH visits	13,371	0	24,876			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	1,335	0	9,402	0.00	8.64	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	182.43	27.00
28.00	Observation Bed Days		0	417			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: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 8/31/2015 3:42 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	432	134	711	1.00
2.00	HMO and other (see instructions)			0	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						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	432	134	711	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
26.25	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: 141323 Component CCN: 143478 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-8 | Date/Time Prepared: 8/31/2015 3:42 pm

				Rural Health Clinic (RHC) I	Cost	
				1.00		
	Clinic Address and Identification					
1.00	Street			28 CHICK STREET		1.00
		City		State	Zip Code	
		1.00		2.00	3.00	
2.00	City, State, Zip Code, County	METROPOLIS		IL	62960	2.00
					1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban				0	3.00
				Grant Award	Date	
				1.00	2.00	
	Source of Federal Funds					
4.00	Community Health Center (Section 330(d), PHS Act)			0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)			0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)			0		6.00
7.00	Appalachian Regional Commission			0		7.00
8.00	Look-Alikes			0		8.00
9.00	OTHER (SPECIFY)			0		9.00
				1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)			N	0	10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			07:30	18:00	07:30	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)		0	0	0	0	15.00

			County				
			4.00				
2.00	City, State, Zip Code, County		MASSAC				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	18:00	07:30	18:00	07:30	18:00	11.00

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

Provider CCN: 141323
Component CCN: 143478

Period:
From 04/01/2014
To 03/31/2015

Worksheet S-8
Date/Time Prepared:
8/31/2015 3:42 pm

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	07:30	16:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet S-10 | Date/Time Prepared: 8/31/2015 3:42 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.445838	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	4,189,789	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	13,980,921	6.00
7.00	Medicaid cost (line 1 times line 6)	6,233,226	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)	2,043,437	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)	2,043,437	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	465,209	0	465,209	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	207,408	0	207,408	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	207,408	0	207,408	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?		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)	1,413,734	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	566,886	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	846,848	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	377,557	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	584,965	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	2,628,402	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A | Date/Time Prepared: 8/31/2015 3:42 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		934,704	934,704	499,196	1,433,900	1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE		0	0	0	0	1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG		0	0	15,600	15,600	1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1,932,207	1,932,207	426,985	2,359,192	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	89,318	3,481,469	3,570,787	0	3,570,787	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,265,531	1,720,008	2,985,539	-251,719	2,733,820	5.00
7.00	00700	OPERATION OF PLANT	271,784	615,829	887,613	-315	887,298	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	20,379	93,780	114,159	0	114,159	8.00
9.00	00900	HOUSEKEEPING	283,286	69,870	353,156	0	353,156	9.00
10.00	01000	DIETARY	264,482	180,902	445,384	-171,503	273,881	10.00
11.00	01100	CAFETERIA	0	0	0	171,192	171,192	11.00
13.00	01300	NURSING ADMINISTRATION	771,890	13,473	785,363	-3,538	781,825	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	223,885	67,589	291,474	0	291,474	16.00
17.00	01700	SOCIAL SERVICE	126,027	10,803	136,830	0	136,830	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,044,148	258,575	1,302,723	-4,507	1,298,216	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	269,421	232,900	502,321	-130,593	371,728	50.00
53.00	05300	ANESTHESIOLOGY	0	158,685	158,685	0	158,685	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	571,623	841,694	1,413,317	-345,823	1,067,494	54.00
60.00	06000	LABORATORY	434,294	590,725	1,025,019	-13,065	1,011,954	60.00
65.00	06500	RESPIRATORY THERAPY	307,314	107,467	414,781	-27,891	386,890	65.00
66.00	06600	PHYSICAL THERAPY	429,742	3,551	433,293	-65	433,228	66.00
69.00	06900	ELECTROCARDIOLOGY	75,895	207,398	283,293	9,052	292,345	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	75,354	12,479	87,833	43,777	131,610	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	38,628	38,628	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	279,553	422,344	701,897	22,397	724,294	73.00
76.00	03020	GERIATRIC PSYCH	170,484	123,364	293,848	0	293,848	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	517,032	313,770	830,802	6,017	836,819	88.00
91.00	09100	EMERGENCY	825,383	679,396	1,504,779	188,532	1,693,311	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	129,750	99,753	229,503	0	229,503	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		479,758	479,758	-479,758	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,446,575	13,652,493	22,099,068	-7,401	22,091,667	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	7,401	7,401	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		TOTAL (SUM OF LINES 118-199)	8,446,575	13,652,493	22,099,068	0	22,099,068	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A | Date/Time Prepared: 8/31/2015 3:42 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-52,364	1,381,536		1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0		1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	15,600		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-533,572	1,825,620		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-243	3,570,544		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	200,858	2,934,678		5.00
7.00	00700	OPERATION OF PLANT	0	887,298		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	114,159		8.00
9.00	00900	HOUSEKEEPING	0	353,156		9.00
10.00	01000	DIETARY	-71	273,810		10.00
11.00	01100	CAFETERIA	0	171,192		11.00
13.00	01300	NURSING ADMINISTRATION	0	781,825		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,499	289,975		16.00
17.00	01700	SOCIAL SERVICE	0	136,830		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-144,165	1,154,051		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	371,728		50.00
53.00	05300	ANESTHESIOLOGY	-157,015	1,670		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,067,494		54.00
60.00	06000	LABORATORY	1,561	1,013,515		60.00
65.00	06500	RESPIRATORY THERAPY	0	386,890		65.00
66.00	06600	PHYSICAL THERAPY	0	433,228		66.00
69.00	06900	ELECTROCARDIOLOGY	-118,571	173,774		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-5,818	125,792		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	38,628		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-11,220	713,074		73.00
76.00	03020	GERIATRIC PSYCH	0	293,848		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-240	836,579		88.00
91.00	09100	EMERGENCY	0	1,693,311		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	229,503		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-822,359	21,269,308		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,401		192.00
192.01	19201	PROMOTION	0	0		192.01
193.00	19300	NONPAID WORKERS	0	0		193.00
200.00		TOTAL (SUM OF LINES 118-199)	-822,359	21,276,709		200.00

RECLASSIFICATIONS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-6 | Date/Time Prepared: 8/31/2015 3:42 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	470,507		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,251		2.00
	TOTALS		0	479,758		
	B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	101,659	69,533		1.00
	TOTALS		101,659	69,533		
	C - RENTAL EXPENSE RECLASS					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	417,734		1.00
2.00	NEW CAP REL COSTS-BLDG EKG	1.02	0	15,600		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	TOTALS		0	433,334		
	D - MED SUPPLIES RECLASS					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	43,777		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
	TOTALS		0	43,777		
	E - DRUGS CHARGED RECLASS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	22,397		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	TOTALS		0	22,397		
	F - POB REAL ESTATE TAXES					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	7,401		1.00
	TOTALS		0	7,401		
	G - IMPLANTABLE SUPPLIES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	38,628		1.00
	TOTALS		0	38,628		
	H - MALPRACTICE EXPENSE RECLASS					
1.00	EMERGENCY	91.00	0	207,546		1.00
	TOTALS		0	207,546		
	I - RECLASS EKG SALARIES					
1.00	ELECTROCARDIOLOGY	69.00	24,652	0		1.00
	TOTALS		24,652	0		
	J - RECLASS RHC BLDG DEPRECIATION					
1.00	RURAL HEALTH CLINIC	88.00	0	6,017		1.00
	TOTALS		0	6,017		
	K - PROPERTY INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	34,706		1.00
	TOTALS		0	34,706		
500.00	Grand Total: Increases		126,311	1,343,097		500.00

RECLASSIFICATIONS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-6 | Date/Time Prepared: 8/31/2015 3:42 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	479,758	11		1.00
2.00		0.00	0	0	11		2.00
	TOTALS		0	479,758			
	B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	101,659	69,533	0		1.00
	TOTALS		101,659	69,533			
	C - RENTAL EXPENSE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,066	10		1.00
2.00	OPERATION OF PLANT	7.00	0	315	10		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	328,271	0		3.00
4.00	LABORATORY	60.00	0	13,065	0		4.00
5.00	RESPIRATORY THERAPY	65.00	0	3,239	0		5.00
6.00	ELECTROCARDIOLOGY	69.00	0	15,600	0		6.00
7.00	OPERATING ROOM	50.00	0	70,778	0		7.00
	TOTALS		0	433,334			
	D - MED SUPPLIES RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	0	4,414	0		1.00
2.00	OPERATING ROOM	50.00	0	20,026	0		2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	377	0		3.00
4.00	EMERGENCY	91.00	0	18,960	0		4.00
	TOTALS		0	43,777			
	E - DRUGS CHARGED RECLASS						
1.00	DIETARY	10.00	0	311	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	3,538	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	93	0		3.00
4.00	OPERATING ROOM	50.00	0	1,161	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	17,175	0		5.00
6.00	PHYSICAL THERAPY	66.00	0	65	0		6.00
7.00	EMERGENCY	91.00	0	54	0		7.00
	TOTALS		0	22,397			
	F - POB REAL ESTATE TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,401	0		1.00
	TOTALS		0	7,401			
	G - IMPLANTABLE SUPPLIES						
1.00	OPERATING ROOM	50.00	0	38,628	0		1.00
	TOTALS		0	38,628			
	H - MALPRACTICE EXPENSE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	207,546	0		1.00
	TOTALS		0	207,546			
	I - RECLASS EKG SALARIES						
1.00	RESPIRATORY THERAPY	65.00	24,652	0	0		1.00
	TOTALS		24,652	0			
	J - RECLASS RHC BLDG DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,017	9		1.00
	TOTALS		0	6,017			
	K - PROPERTY INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	34,706	12		1.00
	TOTALS		0	34,706			
500.00	Grand Total: Decreases		126,311	1,343,097			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 8/31/2015 3:42 pm

			Acquisitions				
		Beginning Balances	Purchases	Donation	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	22,980	43,000	0	43,000	0	1.00
2.00	Land Improvements	1,054,078	0	0	0	0	2.00
3.00	Buildings and Fixtures	19,121,429	54,292	0	54,292	2,292,713	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	7,607,717	4,240,896	0	4,240,896	5,066,729	6.00
7.00	HIT designated Assets	4,100,511	180,806	0	180,806	4,013,075	7.00
8.00	Subtotal (sum of lines 1-7)	31,906,715	4,518,994	0	4,518,994	11,372,517	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	31,906,715	4,518,994	0	4,518,994	11,372,517	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	65,980	0	1.00
2.00	Land Improvements	1,054,078	0	2.00
3.00	Buildings and Fixtures	16,883,008	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	6,781,884	0	6.00
7.00	HIT designated Assets	268,242	0	7.00
8.00	Subtotal (sum of lines 1-7)	25,053,192	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	25,053,192	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-7 Part II Date/Time Prepared: 8/31/2015 3:42 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	934,704	0	0	0	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	1,932,207	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,866,911	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	934,704		1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0		1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0		1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	1,932,207		2.00
3.00	Total (sum of lines 1-2)	0	2,866,911		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 8/31/2015 3:42 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	24,298,998	0	24,298,998	0.761564	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0.000000	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0.000000	0	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	7,607,717	0	7,607,717	0.238436	0	2.00
3.00	Total (sum of lines 1-2)	31,906,715	0	31,906,715	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	928,687	0	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	15,600	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	1,399,255	417,734	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,327,942	433,334	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	418,143	34,706	0	0	1,381,536	1.00
1.01	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0	0	0	1.01
1.02	NEW CAP REL COSTS-BLDG EKG	0	0	0	0	15,600	1.02
2.00	CAP REL COSTS-MVBLE EQUIP	8,631	0	0	0	1,825,620	2.00
3.00	Total (sum of lines 1-2)	426,774	34,706	0	0	3,222,756	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-8 | Date/Time Prepared: 8/31/2015 3:42 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-52,364	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1.01	Investment income - NEW CAP REL COSTS-BLDG AMBULANCE (chapter 2)		0	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	0	1.01
1.02	Investment income - NEW CAP REL COSTS-BLDG EKG (chapter 2)		0	NEW CAP REL COSTS-BLDG EKG	1.02	0	1.02
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-620	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-7,351	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-261,175			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	A	-1,499	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26.01	Depreciation - NEW CAP REL COSTS-BLDG AMBULANCE		0	NEW CAP REL COSTS-BLDG AMBULANCE	1.01	0	26.01
26.02	Depreciation - NEW CAP REL COSTS-BLDG EKG		0	NEW CAP REL COSTS-BLDG EKG	1.02	0	26.02
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	*** Cost Center Deleted ***	67.00		30.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-8 | Date/Time Prepared: 8/31/2015 3:42 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MCHC TERMINATED PLAN	A	251,487	ADMINISTRATIVE & GENERAL	5.00	0	33.00
34.00	OTHER OPERATING REVENUE	B	-71	DIETARY	10.00	0	34.00
35.00	PHARMACY REBATES	B	-11,220	DRUGS CHARGED TO PATIENTS	73.00	0	35.00
36.00	ACCOUNTS PAYABLE DISCOUNT	B	-707	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	ACCOUNTS PAYABLE DISCOUNT	B	-394	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00	PURCHASING REBATES	B	-5,818	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	38.00
39.00	OTHER DISCOUNTS / REBATES	B	-658	ADMINISTRATIVE & GENERAL	5.00	0	39.00
42.00	LOBBYING EXPENSE	A	-2,475	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	CRNA EXPENSES	A	-157,015	ANESTHESIOLOGY	53.00	0	43.00
44.00	RHC MISC INCOME	B	-240	RURAL HEALTH CLINIC	88.00	0	44.00
45.00	COMMUNITY OUTREACH	A	-1,851	ADMINISTRATIVE & GENERAL	5.00	0	45.00
45.01	PATIENT TV DEPRECIATION	A	-1,861	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.01
45.02	PATIENT PHONE SALARY	A	-896	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	PATIENT PHONE BENEFITS	A	-243	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.03
45.04	PATIENT PHONE DEPRECIATION	A	-1,934	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.04
45.05	MARKETING EXPENSE	A	-36,297	ADMINISTRATIVE & GENERAL	5.00	0	45.05
45.06	HITECH DEPRECIATION	A	-529,157	CAP REL COSTS-MVBLE EQUIP	2.00	9	45.06
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-822,359				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: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 8/31/2015 3:42 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	144,165	144,165	0	0	0	1.00
2.00	91.00	EMERGENCY	576,769	0	576,769	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	118,571	118,571	0	0	0	3.00
4.00	60.00	LABORATORY	-1,561	-1,561	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			837,944	261,175	576,769		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	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	3.00
4.00	60.00	LABORATORY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	144,165		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	69.00	ELECTROCARDIOLOGY	0	0	0	118,571		3.00
4.00	60.00	LABORATORY	0	0	0	-1,561		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	261,175		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part I | Date/Time Prepared: 8/31/2015 3:42 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS				
				BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	1,381,536	1,381,536				1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0	0			1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	15,600	0	0	15,600		1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP	1,825,620				1,825,620	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,570,544	6,603	0	0	7,907	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,934,678	354,881	0	0	424,953	5.00
7.00	00700	OPERATION OF PLANT	887,298	126,854	0	0	151,901	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	114,159	26,412	0	0	31,627	8.00
9.00	00900	HOUSEKEEPING	353,156	9,725	0	0	11,646	9.00
10.00	01000	DIETARY	273,810	31,795	0	0	38,073	10.00
11.00	01100	CAFETERIA	171,192	13,303	0	0	15,930	11.00
13.00	01300	NURSING ADMINISTRATION	781,825	5,530	0	0	6,621	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	289,975	25,029	0	1,824	33,710	16.00
17.00	01700	SOCIAL SERVICE	136,830	2,944	0	0	3,525	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,154,051	239,266	0	0	286,509	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	371,728	146,841	0	0	175,835	50.00
53.00	05300	ANESTHESIOLOGY	1,670	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,067,494	79,641	0	0	95,367	54.00
60.00	06000	LABORATORY	1,013,515	19,370	0	0	23,194	60.00
65.00	06500	RESPIRATORY THERAPY	386,890	26,786	0	0	32,075	65.00
66.00	06600	PHYSICAL THERAPY	433,228	56,385	0	0	67,518	66.00
69.00	06900	ELECTROCARDIOLOGY	173,774	26,542	0	13,776	60,020	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	125,792	22,476	0	0	26,914	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	38,628	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	713,074	9,270	0	0	11,100	73.00
76.00	03020	GERIATRIC PSYCH	293,848	23,468	0	0	28,102	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	836,579	30,282	0	0	114,160	88.00
91.00	09100	EMERGENCY	1,693,311	95,401	0	0	114,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	229,503	0	0	0	61,423	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	21,269,308	1,378,804	0	15,600	1,822,348	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,732	0	0	3,272	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,401	0	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	21,276,709	1,381,536	0	15,600	1,825,620	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part I | Date/Time Prepared: 8/31/2015 3:42 pm

		Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			4.00	4A	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,585,054					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	542,880	4,257,392	4,257,392			5.00
7.00	00700	OPERATION OF PLANT	116,589	1,282,642	320,854	1,603,496		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,742	180,940	45,262	47,415	273,617	8.00
9.00	00900	HOUSEKEEPING	121,523	496,050	124,087	17,459	0	9.00
10.00	01000	DIETARY	69,847	413,525	103,444	57,079	0	10.00
11.00	01100	CAFETERIA	43,609	244,034	61,045	23,883	0	11.00
13.00	01300	NURSING ADMINISTRATION	331,122	1,125,098	281,444	9,927	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	96,041	446,579	111,712	44,933	0	16.00
17.00	01700	SOCIAL SERVICE	54,062	197,361	49,370	5,285	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	447,913	2,127,739	532,256	429,538	125,803	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	115,575	809,979	202,617	263,614	12,888	50.00
53.00	05300	ANESTHESIOLOGY	0	1,670	418	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	245,212	1,487,714	372,153	142,975	27,659	54.00
60.00	06000	LABORATORY	186,301	1,242,380	310,783	34,773	0	60.00
65.00	06500	RESPIRATORY THERAPY	121,255	567,006	141,837	48,086	0	65.00
66.00	06600	PHYSICAL THERAPY	184,349	741,480	185,482	101,224	14,177	66.00
69.00	06900	ELECTROCARDIOLOGY	43,132	317,244	79,359	47,649	7,237	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	32,325	207,507	51,908	40,349	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	38,628	9,663	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	119,921	853,365	213,470	16,642	0	73.00
76.00	03020	GERIATRIC PSYCH	73,133	418,551	104,701	42,130	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	221,794	1,202,815	300,885	54,364	1,983	88.00
91.00	09100	EMERGENCY	354,069	2,257,019	564,590	171,266	78,615	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	55,660	346,586	86,699	0	4,759	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,585,054	21,263,304	4,254,039	1,598,591	273,121	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,004	1,502	4,905	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,401	1,851	0	496	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments		0				200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,585,054	21,276,709	4,257,392	1,603,496	273,617	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part I | Date/Time Prepared: 8/31/2015 3:42 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	637,596					9.00
10.00	01000	DIETARY	13,375	587,423				10.00
11.00	01100	CAFETERIA	15,277	0	344,239			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	18,948	1,435,417		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	6,749	0	18,825	0	628,798	16.00
17.00	01700	SOCIAL SERVICE	0	0	5,537	52,501	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	304,933	412,391	100,709	819,900	288,341	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,172	0	14,950	128,327	27,871	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,407	0	31,191	0	145,360	54.00
60.00	06000	LABORATORY	24,235	0	31,191	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	19,511	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	20,431	0	20,609	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	982	0	25,377	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6,214	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,374	0	9,597	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0	85,423	10,428	96,882	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	60,434	0	0	0	0	88.00
91.00	09100	EMERGENCY	74,730	0	50,355	337,807	167,226	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	576,610	497,814	343,931	1,435,417	628,798	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	60,986	89,609	308	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	637,596	587,423	344,239	1,435,417	628,798	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part I | Date/Time Prepared: 8/31/2015 3:42 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
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	310,054					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	310,054		5,451,664	0	5,451,664	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,464,418	0	1,464,418	50.00
53.00	05300	ANESTHESIOLOGY	0	0	2,088	0	2,088	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	2,235,459	0	2,235,459	54.00
60.00	06000	LABORATORY	0	0	1,643,362	0	1,643,362	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	776,440	0	776,440	65.00
66.00	06600	PHYSICAL THERAPY	0	0	1,083,403	0	1,083,403	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	477,848	0	477,848	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	305,978	0	305,978	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	48,291	0	48,291	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	1,096,448	0	1,096,448	73.00
76.00	03020	GERIATRIC PSYCH	0	0	758,115	0	758,115	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	1,620,481	0	1,620,481	88.00
91.00	09100	EMERGENCY	0	0	3,701,608	0	3,701,608	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	438,044	0	438,044	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	310,054	0	21,103,647	0	21,103,647	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	12,411	0	12,411	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	160,651	0	160,651	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	310,054	0	21,276,709	0	21,276,709	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part II | Date/Time Prepared: 8/31/2015 3:42 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	NEW BLDG AMBULANCE	NEW BLDG EKG	MVBLE EQUIP	
			0	1.00	1.01	1.02	2.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	6,603	0	0	7,907	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	354,881	0	0	424,953	5.00
7.00	00700	OPERATION OF PLANT	0	126,854	0	0	151,901	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	26,412	0	0	31,627	8.00
9.00	00900	HOUSEKEEPING	0	9,725	0	0	11,646	9.00
10.00	01000	DIETARY	0	31,795	0	0	38,073	10.00
11.00	01100	CAFETERIA	0	13,303	0	0	15,930	11.00
13.00	01300	NURSING ADMINISTRATION	0	5,530	0	0	6,621	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	25,029	0	1,824	33,710	16.00
17.00	01700	SOCIAL SERVICE	0	2,944	0	0	3,525	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	239,266	0	0	286,509	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	146,841	0	0	175,835	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	79,641	0	0	95,367	54.00
60.00	06000	LABORATORY	0	19,370	0	0	23,194	60.00
65.00	06500	RESPIRATORY THERAPY	0	26,786	0	0	32,075	65.00
66.00	06600	PHYSICAL THERAPY	0	56,385	0	0	67,518	66.00
69.00	06900	ELECTROCARDIOLOGY	0	26,542	0	13,776	60,020	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	22,476	0	0	26,914	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,270	0	0	11,100	73.00
76.00	03020	GERIATRIC PSYCH	0	23,468	0	0	28,102	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	30,282	0	0	114,160	88.00
91.00	09100	EMERGENCY	0	95,401	0	0	114,238	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	61,423	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,378,804	0	15,600	1,822,348	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,732	0	0	3,272	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,381,536	0	15,600	1,825,620	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part II | Date/Time Prepared: 8/31/2015 3:42 pm

		Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			2A	4.00	5.00	7.00	8.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	14,510	14,510				4.00
5.00	00500	ADMINISTRATIVE & GENERAL	779,834	2,197	782,031			5.00
7.00	00700	OPERATION OF PLANT	278,755	472	58,937	338,164		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	58,039	35	8,314	9,999	76,387	8.00
9.00	00900	HOUSEKEEPING	21,371	492	22,793	3,682	0	9.00
10.00	01000	DIETARY	69,868	283	19,001	12,037	0	10.00
11.00	01100	CAFETERIA	29,233	176	11,213	5,037	0	11.00
13.00	01300	NURSING ADMINISTRATION	12,151	1,340	51,698	2,093	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	60,563	389	20,520	9,476	0	16.00
17.00	01700	SOCIAL SERVICE	6,469	219	9,069	1,114	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	525,775	1,813	97,770	90,588	35,122	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	322,676	468	37,219	55,594	3,598	50.00
53.00	05300	ANESTHESIOLOGY	0	0	77	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	175,008	992	68,360	30,152	7,722	54.00
60.00	06000	LABORATORY	42,564	754	57,087	7,333	0	60.00
65.00	06500	RESPIRATORY THERAPY	58,861	491	26,054	10,141	0	65.00
66.00	06600	PHYSICAL THERAPY	123,903	746	34,071	21,347	3,958	66.00
69.00	06900	ELECTROCARDIOLOGY	100,338	175	14,577	10,049	2,020	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	49,390	131	9,535	8,509	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	1,775	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,370	485	39,212	3,510	0	73.00
76.00	03020	GERIATRIC PSYCH	51,570	296	19,232	8,885	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	144,442	898	55,269	11,465	554	88.00
91.00	09100	EMERGENCY	209,639	1,433	103,706	36,119	21,947	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	61,423	225	15,926	0	1,328	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,216,752	14,510	781,415	337,130	76,249	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,004	0	276	1,034	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	340	0	138	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments	0					200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,222,756	14,510	782,031	338,164	76,387	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part II | Date/Time Prepared: 8/31/2015 3:42 pm

		Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	
			9.00	10.00	11.00	13.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING	48,338					9.00
10.00	01000	DIETARY	1,014	102,203				10.00
11.00	01100	CAFETERIA	1,158	0	46,817			11.00
13.00	01300	NURSING ADMINISTRATION	0	0	2,577	69,859		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	512	0	2,560	0	94,020	16.00
17.00	01700	SOCIAL SERVICE	0	0	753	2,555	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	23,118	71,750	13,698	39,904	43,114	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	316	0	2,033	6,245	4,167	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,154	0	4,242	0	21,735	54.00
60.00	06000	LABORATORY	1,837	0	4,242	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,479	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,549	0	2,803	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	74	0	3,451	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	845	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	256	0	1,305	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0	14,862	1,418	4,715	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	4,582	0	0	0	0	88.00
91.00	09100	EMERGENCY	5,665	0	6,848	16,440	25,004	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	43,714	86,612	46,775	69,859	94,020	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	4,624	15,591	42	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	48,338	102,203	46,817	69,859	94,020	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B Part II | Date/Time Prepared: 8/31/2015 3:42 pm

		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	19.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
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	20,179					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0				19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,179		962,831	0	962,831	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		432,316	0	432,316	50.00
53.00	05300	ANESTHESIOLOGY	0		77	0	77	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		310,365	0	310,365	54.00
60.00	06000	LABORATORY	0		113,817	0	113,817	60.00
65.00	06500	RESPIRATORY THERAPY	0		97,026	0	97,026	65.00
66.00	06600	PHYSICAL THERAPY	0		188,377	0	188,377	66.00
69.00	06900	ELECTROCARDIOLOGY	0		130,684	0	130,684	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		68,410	0	68,410	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		1,775	0	1,775	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		65,138	0	65,138	73.00
76.00	03020	GERIATRIC PSYCH	0		100,978	0	100,978	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		217,210	0	217,210	88.00
91.00	09100	EMERGENCY	0		426,801	0	426,801	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0		78,902	0	78,902	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20,179	0	3,194,707	0	3,194,707	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		7,314	0	7,314	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		20,735	0	20,735	192.00
192.01	19201	PROMOTION	0		0	0	0	192.01
193.00	19300	NONPAID WORKERS	0		0	0	0	193.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	20,179	0	3,222,756	0	3,222,756	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B-1 | Date/Time Prepared: 8/31/2015 3:42 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	NEW BLDG AMBULANCE (SQUARE FEET)	NEW BLDG EKG (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
			1.00	1.01	1.02	2.00	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	84,948					1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE	0	0				1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG	0	0	1,642			1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP				93,744		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	406	0	0	406	8,357,257	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,821	0	0	21,821	1,265,531	5.00
7.00	00700	OPERATION OF PLANT	7,800	0	0	7,800	271,784	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,624	0	0	1,624	20,379	8.00
9.00	00900	HOUSEKEEPING	598	0	0	598	283,286	9.00
10.00	01000	DIETARY	1,955	0	0	1,955	162,823	10.00
11.00	01100	CAFETERIA	818	0	0	818	101,659	11.00
13.00	01300	NURSING ADMINISTRATION	340	0	0	340	771,890	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,539	0	192	1,731	223,885	16.00
17.00	01700	SOCIAL SERVICE	181	0	0	181	126,027	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	14,712	0	0	14,712	1,044,148	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,029	0	0	9,029	269,421	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,897	0	0	4,897	571,623	54.00
60.00	06000	LABORATORY	1,191	0	0	1,191	434,294	60.00
65.00	06500	RESPIRATORY THERAPY	1,647	0	0	1,647	282,662	65.00
66.00	06600	PHYSICAL THERAPY	3,467	0	0	3,467	429,742	66.00
69.00	06900	ELECTROCARDIOLOGY	1,632	0	1,450	3,082	100,547	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,382	0	0	1,382	75,354	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	570	0	0	570	279,553	73.00
76.00	03020	GERIATRIC PSYCH	1,443	0	0	1,443	170,484	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,862	0	0	5,862	517,032	88.00
91.00	09100	EMERGENCY	5,866	0	0	5,866	825,383	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	3,154	129,750	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	84,780	0	1,642	93,576	8,357,257	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	168	0	0	168	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,381,536	0	15,600	1,825,620	3,585,054	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	16.263314	0.000000	9.500609	19.474526	0.428975	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)					14,510	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)					0.001736	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B-1 | Date/Time Prepared: 8/31/2015 3:42 pm

		Cost Center Description	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (TIME SPENT)	
			5A	5.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-4,257,392	17,019,317				5.00
7.00	00700	OPERATION OF PLANT	0	1,282,642	54,921			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	180,940	1,624	2,760		8.00
9.00	00900	HOUSEKEEPING	0	496,050	598	0	51,960	9.00
10.00	01000	DIETARY	0	413,525	1,955	0	1,090	10.00
11.00	01100	CAFETERIA	0	244,034	818	0	1,245	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,125,098	340	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	446,579	1,539	0	550	16.00
17.00	01700	SOCIAL SERVICE	0	197,361	181	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	2,127,739	14,712	1,269	24,850	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	809,979	9,029	130	340	50.00
53.00	05300	ANESTHESIOLOGY	0	1,670	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,487,714	4,897	279	2,315	54.00
60.00	06000	LABORATORY	0	1,242,380	1,191	0	1,975	60.00
65.00	06500	RESPIRATORY THERAPY	0	567,006	1,647	0	1,590	65.00
66.00	06600	PHYSICAL THERAPY	0	741,480	3,467	143	1,665	66.00
69.00	06900	ELECTROCARDIOLOGY	0	317,244	1,632	73	80	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	207,507	1,382	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	38,628	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	853,365	570	0	275	73.00
76.00	03020	GERIATRIC PSYCH	0	418,551	1,443	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,202,815	1,862	20	4,925	88.00
91.00	09100	EMERGENCY	0	2,257,019	5,866	793	6,090	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	346,586	0	48	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-4,257,392	17,005,912	54,753	2,755	46,990	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,004	168	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	7,401	0	5	4,970	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)		4,257,392	1,603,496	273,617	637,596	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)		0.250151	29.196409	99.136594	12.270901	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)		782,031	338,164	76,387	48,338	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)		0.045950	6.157280	27.676449	0.930293	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B-1 | Date/Time Prepared: 8/31/2015 3:42 pm

		Cost Center Description	DIETARY (MEALS SERVED)	CAFETERIA (FTE)	NURSING ADMINISTRATION (NURSING FTES)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (ASSIGNEDTIMES)	
			10.00	11.00	13.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE						1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG						1.02
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
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	12,488					10.00
11.00	01100	CAFETERIA	0	11,191				11.00
13.00	01300	NURSING ADMINISTRATION	0	616	117,729			13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	612	0	138,750		16.00
17.00	01700	SOCIAL SERVICE	0	180	4,306	0	100	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,767	3,274	67,246	63,625	100	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	486	10,525	6,150	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,014	0	32,075	0	54.00
60.00	06000	LABORATORY	0	1,014	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	670	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	825	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	202	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	312	0	0	0	73.00
76.00	03020	GERIATRIC PSYCH	1,816	339	7,946	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	1,637	27,706	36,900	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	10,583	11,181	117,729	138,750	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,905	10	0	0	0	192.00
192.01	19201	PROMOTION	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
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)	587,423	344,239	1,435,417	628,798	310,054	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	47.038997	30.760343	12.192552	4.531877	3,100.540000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	102,203	46,817	69,859	94,020	20,179	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	8.184097	4.183451	0.593388	0.677622	201.790000	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B-1 | Date/Time Prepared: 8/31/2015 3:42 pm

		Cost Center Description	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
			19.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
1.01	00101	NEW CAP REL COSTS-BLDG AMBULANCE		1.01
1.02	00102	NEW CAP REL COSTS-BLDG EKG		1.02
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
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		30.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
60.00	06000	LABORATORY	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
76.00	03020	GERIATRIC PSYCH	0	76.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	93.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0	95.00
		SPECIAL PURPOSE COST CENTERS		
113.00	11300	INTEREST EXPENSE		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201	PROMOTION	0	192.01
193.00	19300	NONPAID WORKERS	0	193.00
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)	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet B-2 | Date/Time Prepared: 8/31/2015 3:42 pm

		Description	Worksheet Part	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet C Part I Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,451,664		5,451,664	0	0	30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,464,418		1,464,418	0	0	50.00
53.00	05300	ANESTHESIOLOGY	2,088		2,088	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,235,459		2,235,459	0	0	54.00
60.00	06000	LABORATORY	1,643,362		1,643,362	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	776,440	0	776,440	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,083,403	0	1,083,403	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	477,848		477,848	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	305,978		305,978	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	48,291		48,291	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,096,448		1,096,448	0	0	73.00
76.00	03020	GERIATRIC PSYCH	758,115		758,115	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,620,481		1,620,481	0	0	88.00
91.00	09100	EMERGENCY	3,701,608		3,701,608	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	719,062		719,062		0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0		0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	438,044		438,044	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	21,822,709	0	21,822,709	0	0	200.00
201.00		Less Observation Beds	719,062		719,062		0	201.00
202.00		Total (see instructions)	21,103,647	0	21,103,647	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet C Part I Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,892,898		2,892,898			30.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,980	2,020,645	2,060,625	0.710667	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	7,107	460,790	467,897	0.004463	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,348,280	16,165,150	18,513,430	0.120748	0.000000	54.00
60.00	06000	LABORATORY	1,547,517	3,806,760	5,354,277	0.306925	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	679,936	193,069	873,005	0.889388	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	91,910	998,495	1,090,405	0.993579	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	631,544	1,772,497	2,404,041	0.198769	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,859	15,169	31,028	9.861351	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	57,941	57,941	0.833451	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,311,191	1,242,270	2,553,461	0.429397	0.000000	73.00
76.00	03020	GERIATRIC PSYCH	0	470,557	470,557	1.611101	0.000000	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	692,483	692,483			88.00
91.00	09100	EMERGENCY	3,959,579	3,838,356	7,797,935	0.474691	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	14,896	121,223	136,119	5.282598	0.000000	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0.000000	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,938,660	1,938,660	0.225952	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	13,540,697	33,794,065	47,334,762			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	13,540,697	33,794,065	47,334,762			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet C Part I Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.000000		50.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
60.00	06000	LABORATORY	0.000000		60.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
76.00	03020	GERIATRIC PSYCH	0.000000		76.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part II Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	432,316	2,060,625	0.209798	2,250	472	50.00
53.00	05300	ANESTHESIOLOGY	77	467,897	0.000165	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	310,365	18,513,430	0.016764	810,221	13,583	54.00
60.00	06000	LABORATORY	113,817	5,354,277	0.021257	816,200	17,350	60.00
65.00	06500	RESPIRATORY THERAPY	97,026	873,005	0.111140	355,068	39,462	65.00
66.00	06600	PHYSICAL THERAPY	188,377	1,090,405	0.172759	15,449	2,669	66.00
69.00	06900	ELECTROCARDIOLOGY	130,684	2,404,041	0.054360	290,075	15,768	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,410	31,028	2.204783	10,453	23,047	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,775	57,941	0.030635	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,138	2,553,461	0.025510	744,174	18,984	73.00
76.00	03020	GERIATRIC PSYCH	100,978	470,557	0.214592	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	217,210	692,483	0.313668	0	0	88.00
91.00	09100	EMERGENCY	426,801	7,797,935	0.054733	2,742	150	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	145,682	136,119	1.070255	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	2,298,656	42,503,204		3,046,632	131,485	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part IV | Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.00	03020	GERIATRIC PSYCH	0	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
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
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part IV | Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,060,625	0.000000	0.000000	2,250	50.00
53.00	05300	ANESTHESIOLOGY	0	467,897	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	18,513,430	0.000000	0.000000	810,221	54.00
60.00	06000	LABORATORY	0	5,354,277	0.000000	0.000000	816,200	60.00
65.00	06500	RESPIRATORY THERAPY	0	873,005	0.000000	0.000000	355,068	65.00
66.00	06600	PHYSICAL THERAPY	0	1,090,405	0.000000	0.000000	15,449	66.00
69.00	06900	ELECTROCARDIOLOGY	0	2,404,041	0.000000	0.000000	290,075	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	31,028	0.000000	0.000000	10,453	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	57,941	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,553,461	0.000000	0.000000	744,174	73.00
76.00	03020	GERIATRIC PSYCH	0	470,557	0.000000	0.000000	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	692,483	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	7,797,935	0.000000	0.000000	2,742	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	136,119	0.000000	0.000000	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	42,503,204			3,046,632	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part IV | Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
76.00	03020	GERIATRIC PSYCH	0	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part V Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.710667	0	722,292	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.004463	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120748	0	5,510,602	0	0	54.00
60.00	06000	LABORATORY	0.306925	0	1,487,158	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.889388	0	44,517	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.993579	0	282,166	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198769	0	723,089	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9.861351	0	15,169	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.833451	0	48,537	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429397	0	760,064	0	0	73.00
76.00	03020	GERIATRIC PSYCH	1.611101	0	464,928	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.474691	0	1,081,713	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5.282598	0	52,016	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.225952		0			95.00
200.00		Subtotal (see instructions)		0	11,192,251	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	11,192,251	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part V Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	513,309	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	665,394	0		54.00
60.00	06000	LABORATORY	456,446	0		60.00
65.00	06500	RESPIRATORY THERAPY	39,593	0		65.00
66.00	06600	PHYSICAL THERAPY	280,354	0		66.00
69.00	06900	ELECTROCARDIOLOGY	143,728	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	149,587	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	40,453	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	326,369	0		73.00
76.00	03020	GERIATRIC PSYCH	749,046	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	513,479	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	274,780	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	4,152,538	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	4,152,538	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141323 | Component CCN: 14Z323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part V | Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.710667	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.004463	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120748	0	0	0	0	54.00
60.00	06000	LABORATORY	0.306925	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.889388	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.993579	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198769	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9.861351	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.833451	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429397	0	0	0	0	73.00
76.00	03020	GERIATRIC PSYCH	1.611101	0	0	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	0.474691	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5.282598	0	0	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.225952		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141323 | Component CCN: 14Z323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D Part V | Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
76.00	03020	GERIATRIC PSYCH	0	0		76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D-1 | Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Hospital | Cost

	Cost Center Description		
		1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,240	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,756	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2,339	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	243	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)	156	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	85	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,840	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)	243	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)	156	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	132.61	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	132.61	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,451,664	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)	11,272	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	699,296	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,752,368	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)	4,752,368	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)	1,724.37	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,172,841	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)	3,172,841	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D-1 | Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	1,162,674	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	4,335,515	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)	419,022	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	269,002	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	688,024	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/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR 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)	417	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,724.37	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	719,062	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D-1 | Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	962,831	4,752,368	0.202600	719,062	145,682	90.00
91.00	Nursing School cost	0	4,752,368	0.000000	719,062	0	91.00
92.00	Allied health cost	0	4,752,368	0.000000	719,062	0	92.00
93.00	All other Medical Education	0	4,752,368	0.000000	719,062	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D-3 | Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		1,400,191		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.710667	2,250	1,599	50.00
53.00	05300	ANESTHESIOLOGY	0.004463	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120748	810,221	97,833	54.00
60.00	06000	LABORATORY	0.306925	816,200	250,512	60.00
65.00	06500	RESPIRATORY THERAPY	0.889388	355,068	315,793	65.00
66.00	06600	PHYSICAL THERAPY	0.993579	15,449	15,350	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198769	290,075	57,658	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9.861351	10,453	103,081	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.833451	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429397	744,174	319,546	73.00
76.00	03020	GERIATRIC PSYCH	1.611101	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.474691	2,742	1,302	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5.282598	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		3,046,632	1,162,674	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)		3,046,632		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141323 | Component CCN: 14Z323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet D-3 | Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.710667	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.004463	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.120748	62,450	7,541	54.00
60.00	06000	LABORATORY	0.306925	68,214	20,937	60.00
65.00	06500	RESPIRATORY THERAPY	0.889388	57,333	50,991	65.00
66.00	06600	PHYSICAL THERAPY	0.993579	56,432	56,070	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198769	2,465	490	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9.861351	1,885	18,589	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.833451	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.429397	139,324	59,825	73.00
76.00	03020	GERIATRIC PSYCH	1.611101	0	0	76.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	0.474691	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5.282598	0	0	92.00
93.00	04040	OTHER OUTPATIENT SERVICES	0.000000	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		388,103	214,443	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)		388,103		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141323	Period: From 04/01/2014 To 03/31/2015	Worksheet E Part B Date/Time Prepared: 8/31/2015 3:42 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	4,152,538	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)	4,152,538	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, line 69, col. 4)	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)	4,194,063	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)	26,122	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,977,179	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} (for CAH, see instructions)	2,190,762	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	2,190,762	30.00
31.00	Primary payer payments	378	31.00
32.00	Subtotal (line 30 minus line 31)	2,190,384	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)	645,339	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	490,458	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	504,430	36.00
37.00	Subtotal (see instructions)	2,680,842	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	2,680,842	40.00
40.01	Sequestration adjustment (see instructions)	53,617	40.01
41.00	Interim payments	2,010,103	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	617,122	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: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 8/31/2015 3:42 pm

Title XVIII | Hospital | Cost

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,840,148		2,096,575	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	10/16/2014	123,504	10/16/2014	477,508	3.01
3.02		03/24/2015	1,474,519		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0	03/24/2015	563,980	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)		1,598,023		-86,472	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)		4,438,171		2,010,103	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		617,122	6.01
6.02	SETTLEMENT TO PROGRAM		454,940		0	6.02
7.00	Total Medicare program liability (see instructions)		3,983,231		2,627,225	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: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 8/31/2015 3:42 pm

Component CCN: 14Z323 | 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		658,391		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	10/16/2014	14,335		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	03/24/2015	156,104		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)		-141,769		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)		516,622		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		369,460		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		886,082		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: 141323	Period: From 04/01/2014 To 03/31/2015	Worksheet E-1 Part II Date/Time Prepared: 8/31/2015 3:42 pm
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD 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	711	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,840	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	188	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,339	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	47,334,762	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	465,209	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	500,687	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	500,687	8.00
9.00	Sequestration adjustment amount (see instructions)	10,014	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	490,673	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & 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)	490,673	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141323 Component CCN: 14Z323	Period: From 04/01/2014 To 03/31/2015	Worksheet E-2 Date/Time Prepared: 8/31/2015 3:42 pm
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	694,904	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 Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	216,587	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	399	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)	911,491	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	911,491	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)	911,491	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	7,602	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)	903,889	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)	425	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	276	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18.00
19.00	Total (see instructions)	904,165	0	19.00
19.01	Sequestration adjustment (see instructions)	18,083	0	19.01
20.00	Interim payments	516,622	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)	369,460	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141323	Period: From 04/01/2014 To 03/31/2015	Worksheet E-3 Part V Date/Time Prepared: 8/31/2015 3:42 pm
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	4,335,515	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)	4,335,515	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	4,378,870	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)	4,378,870	19.00
20.00	Deductibles (exclude professional component)	384,011	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3,994,859	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	3,994,859	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	91,661	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	69,662	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	74,334	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	4,064,521	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)	4,064,521	30.00
30.01	Sequestration adjustment (see instructions)	81,290	30.01
31.00	Interim payments	4,438,171	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)	-454,940	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: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet G | Date/Time Prepared: 8/31/2015 3:42 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	11,134,128	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	15,815,963	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,631,419	0	0	0	6.00
7.00	Inventory	339,541	0	0	0	7.00
8.00	Prepaid expenses	213,447	0	0	0	8.00
9.00	Other current assets	13,872	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)	17,885,532	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	65,980	0	0	0	12.00
13.00	Land improvements	1,054,078	0	0	0	13.00
14.00	Accumulated depreciation	-497,817	0	0	0	14.00
15.00	Buildings	16,883,008	0	0	0	15.00
16.00	Accumulated depreciation	-5,763,363	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	6,781,883	0	0	0	23.00
24.00	Accumulated depreciation	-3,136,960	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	268,243	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	15,655,052	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	1,927,893	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	346,462	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,274,355	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	35,814,939	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	703,804	0	0	0	37.00
38.00	Salaries, wages, and fees payable	704,520	0	0	0	38.00
39.00	Payroll taxes payable	391,759	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	681,008	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	2,481,091	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	14,820,742	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	14,820,742	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	17,301,833	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	18,513,106				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)	18,513,106	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	35,814,939	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet G-1 | Date/Time Prepared: 8/31/2015 3:42 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		17,976,919		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		536,187				2.00
3.00	Total (sum of line 1 and line 2)		18,513,106		0		3.00
4.00	Additions (credit adjustments) (specify)	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)		18,513,106		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)		18,513,106		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 8/31/2015 3:42 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	2,876,115		2,876,115	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	195,000		195,000	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)	3,071,115		3,071,115	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)	3,071,115		3,071,115	17.00
18.00	Ancillary services	7,166,107	30,702,130	37,868,237	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	692,483	692,483	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,938,660	1,938,660	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	10,237,222	33,333,273	43,570,495	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		22,099,068		29.00
30.00	BAD DEBT EXPENSE	1,413,734			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		1,413,734		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		23,512,802		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141323	Period: From 04/01/2014 To 03/31/2015	Worksheet G-3 Date/Time Prepared: 8/31/2015 3:42 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	43,570,495	1.00
2.00	Less contractual allowances and discounts on patients' accounts	20,337,739	2.00
3.00	Net patient revenues (line 1 minus line 2)	23,232,756	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	23,512,802	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-280,046	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	52,983	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	17,767	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	71,878	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	1,497	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	112,334	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	559,774	24.00
25.00	Total other income (sum of lines 6-24)	816,233	25.00
26.00	Total (line 5 plus line 25)	536,187	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	536,187	29.00

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

Provider CCN: 141323 Component CCN: 143478 | Period: From 04/01/2014 To 03/31/2015 | Worksheet M-1 | Date/Time Prepared: 8/31/2015 3:42 pm

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	134,887	0	134,887	0	134,887	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	192,686	0	192,686	0	192,686	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	327,573	0	327,573	0	327,573	10.00
11.00	Physician Services Under Agreement	0	223,431	223,431	0	223,431	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	30,868	30,868	0	30,868	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	254,299	254,299	0	254,299	14.00
15.00	Medical Supplies	0	40,784	40,784	0	40,784	15.00
16.00	Transportation (Health Care Staff)	0	817	817	0	817	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	41,601	41,601	0	41,601	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	327,573	295,900	623,473	0	623,473	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	14,113	14,113	0	14,113	29.00
30.00	Administrative Costs	189,459	3,757	193,216	0	193,216	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	189,459	17,870	207,329	0	207,329	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	517,032	313,770	830,802	0	830,802	32.00

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

Provider CCN: 141323 | Component CCN: 143478 | Period: From 04/01/2014 To 03/31/2015 | Worksheet M-1 | Date/Time Prepared: 8/31/2015 3:42 pm

Rural Health Clinic (RHC) I | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)		
		6.00	7.00		
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physician	0	134,887		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	192,686		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	327,573		10.00
11.00	Physician Services Under Agreement	0	223,431		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	30,868		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	254,299		14.00
15.00	Medical Supplies	0	40,784		15.00
16.00	Transportation (Health Care Staff)	0	817		16.00
17.00	Depreciation-Medical Equipment	6,017	6,017		17.00
18.00	Professional Liability Insurance	0	0		18.00
19.00	Other Health Care Costs	0	0		19.00
20.00	Allowable GME Costs	0	0		20.00
21.00	Subtotal (sum of lines 15 through 20)	6,017	47,618		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	6,017	629,490		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	14,113		29.00
30.00	Administrative Costs	-240	192,976		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-240	207,089		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	5,777	836,579		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141323 | Period: From 04/01/2014 To 03/31/2015 | Worksheet M-2

Component CCN: 143478 | Date/Time Prepared: 8/31/2015 3:42 pm

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.31	3,892	4,200	1,302		1.00
2.00	Physician Assistant	1.77	5,510	2,100	3,717		2.00
3.00	Nurse Practitioner	0.00	0	2,100	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	2.08	9,402		5,019	9,402	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)	2.08	9,402			9,402	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)					629,490	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)					629,490	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)					207,089	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					783,902	15.00
16.00	Total overhead (sum of lines 14 and 15)					990,991	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					990,991	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					990,991	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,620,481	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 141323 Component CCN: 143478	Period: From 04/01/2014 To 03/31/2015	Worksheet M-3 Date/Time Prepared: 8/31/2015 3:42 pm
	Title XVIII	Rural Health Clinic (RHC) I	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		1,620,481	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)		1,620,481	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		9,402	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)		9,402	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		172.35	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	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	172.35	172.35	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,335	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	230,087	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) *		230,087	16.00
16.01	Total program charges (see instructions)(from contractor's records)		128,655	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		500	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		894	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.)		183,354	16.04
16.05	Total program cost (see instructions)		184,248	16.05
17.00	Primary payer amounts		0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		0	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		24,588	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		184,248	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)		184,248	22.00
23.00	Allowable bad debts (see instructions)		8,539	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		6,490	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		190,738	26.00
26.01	Sequestration adjustment (see instructions)		3,815	26.01
27.00	Interim payments		168,594	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)		18,329	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

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

Provider CCN: 141323 Component CCN: 143478

Period: From 04/01/2014 To 03/31/2015

Worksheet M-5

Date/Time Prepared: 8/31/2015 3:42 pm

Rural Health Clinic (RHC) I

Cost

		Part B mm/dd/yyyy	Part B Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		168,063	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		10/16/2014	531	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		531	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		168,594	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		18,329	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		186,923	7.00

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