

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet S Parts I-III Date/Time Prepared: 8/26/2015 10:54 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 8/26/2015 Time: 10:54 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FERRELL HOSPITAL (141324) 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 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	34,154	180,205	1	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing bed - SNF	0	59,752	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		-25,942		0	10.00
200.00 Total	0	93,906	154,263	1	0	200.00

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141324		Period: From 04/01/2014 To 03/31/2015		Worksheet S-2 Part I Date/Time Prepared: 8/26/2015 10:48 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1201 PINE STREET	PO Box:							1.00	
2.00	City: EL DORADO	State: IL		Zip Code: 62930		County: SALINE			2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
						V	XVIII	XIX		
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	FERRELL HOSPITAL	141324	14999	1	02/01/2003	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	FERRELL SWINGBED SNF	14Z324	14999		02/01/2003	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	FERRELL HOSPITAL CLINIC	148506	14999		04/01/2009	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FOHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					04/01/2014	03/31/2015		20.00	
21.00	Type of Control (see instructions)					2			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N		22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					2		N	23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0	0		25.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet S-2 Part I Date/Time Prepared: 8/26/2015 10:48 am		
		Urban/Rural	S	Date of Geogr		
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.		2			26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		2			27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0			35.00
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.		0			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	XVII	XIX		
		1.00	2.00	3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)		N		N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.		N		N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.		N		N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N		N	48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.		N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 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
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06

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

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010						
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))
		1.00	2.00	3.00	4.00	5.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000
				1.00	2.00	3.00
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, 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	N		90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N		91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N		92.00		
93.00	Does this facility operate an ICF/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.			Y			108.00		
				Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			Y	Y	Y	N	109.00	
							1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.						N	110.00	
							1.00	2.00	3.00
Miscellaneous Cost Reporting Information									
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, §2208.1.			N			0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1				118.00	
				Premiums 1.00	Losses 2.00	Insurance 3.00			
118.01	List amounts of malpractice premiums and paid losses:			71,652	0		0	118.01	
							1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.			N				118.02	
119.00	DO NOT USE THIS LINE							119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			N				121.00	
Transplant Center Information									
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							127.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet S-2 Part I Date/Time Prepared: 8/26/2015 10:48 am			
		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:			
142.00	Street:	PO Box:					
143.00	City:	State:		Zip Code:			
			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		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
					1.00		
165.00	Multi campus Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.				N		
		Name	County	State	Zip Code	CBSA	FTE/Campus
		0	1.00	2.00	3.00	4.00	5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00
							1.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under 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)						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: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet S-2 Part I Date/Time Prepared: 8/26/2015 10:48 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		04/01/2014	03/31/2015 170.00
				1.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, 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: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet S-2 Part II Date/Time Prepared: 8/26/2015 10:48 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		Y		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for 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
			Y/N	Date	Y/N
			1.00	2.00	3.00
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	06/22/2015	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		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		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		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet S-2 Part II Date/Time Prepared: 8/26/2015 10:48 am
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	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			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.			Y	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.			Y	33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			Y	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			N	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				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.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				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.	JOSH		WILKS	41.00
42.00	Enter the employer/company name of the cost report preparer.	CLIFTONLARSONALLEN LLP			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	314-925-4477		JOSHUA.WILKS@CLACONNECT.COM	43.00

		Part B		
		Date		
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			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)	06/22/2015		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.		PRINCIPAL	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: 141324

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

Worksheet S-3
Part I
Date/Time Prepared:
8/26/2015 10:48 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Ti tle 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	52,200.00	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	52,200.00	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	52,200.00	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 RHC (CONSOLIDATED)	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: 141324

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

Worksheet S-3
Part I
Date/Time Prepared:
8/26/2015 10:48 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,534	334	2,175			1.00
2.00 HMO and other (see instructions)	0	0				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	468	0	468			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	49			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	2,002	334	2,692			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)	2,002	334	2,692	0.00	134.86	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RHC (CONSOLIDATED)	7,065	0	23,181	0.00	17.39	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				0.00	152.25	27.00
28.00 Observation Bed Days		0	402			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: 141324

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

Worksheet S-3
Part I
Date/Time Prepared:
8/26/2015 10:48 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
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	415	144	722	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	415	144	722	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 RHC (CONSOLIDATED)	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: 141324 Component CCN: 148506	Period: From 04/01/2014 To 03/31/2015	Worksheet S-8 Date/Time Prepared: 8/26/2015 10:48 am Cost	
				Rural Health Clinic (RHC) I	
				1.00	
1.00	Clinic Address and Identification Street		1201 PINE STREET		1.00
		City	State	Zip Code	
		1.00	2.00	3.00	
2.00	City, State, Zip Code, County		EL DORADO IL 62930		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	
		from	to	from	to
		1.00	2.00	3.00	4.00
		Tuesday		from	
				5.00	
11.00	Facility hours of operations (1) Clinic		07:00	19:00	07:00 11.00
				1.00	2.00
12.00	Have you received an approval for an exception to the productivity standard?		N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.		Y		2 13.00
		Provider name		CCN number	
		1.00		2.00	
14.00	Provider name, CCN number		FERRELL HOSPITAL CLINIC		148506 14.00
14.01			EL DORADO		148507 14.01
		Y/N	V	XVIII	XIX
		1.00	2.00	3.00	4.00
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)		N		0 0 0 0 0 15.00
		County			
		4.00			
2.00	City, State, Zip Code, County		SALINE		2.00
		Tuesday		Wednesday	
		to	from	to	from
		6.00	7.00	8.00	9.00
		Thursday		to	
				10.00	
11.00	Facility hours of operations (1) Clinic		19:00	07:00	19:00 07:00 19:00 11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 141324 Component CCN: 148506	Period: From 04/01/2014 To 03/31/2015	Worksheet S-8 Date/Time Prepared: 8/26/2015 10:48 am Cost
		Rural Health Clinic (RHC) I	

	Friday		Saturday			
	from	to	from	to		
	11.00	07:00	19:00	08:00		

Facility hours of operations (1)

Clinic

07:00

19:00

08:00

14:00

11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet S-10
				Date/Time Prepared: 8/26/2015 10:48 am
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.393515	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		1,433,260	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		38,431	5.00
6.00	Medicaid charges		8,539,684	6.00
7.00	Medicaid cost (line 1 times line 6)		3,360,494	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,888,803	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		2,858	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,888,803	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	0	158,854	158,854
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	0	62,511	62,511
22.00	Partial payment by patients approved for charity care	0	2,180	2,180
23.00	Cost of charity care (line 21 minus line 22)	0	60,331	60,331
				1.00
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		0	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)		540,259	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		-540,259	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		-212,600	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		-152,269	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,736,534	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141324

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

Worksheet A
Date/Time Prepared:
8/26/2015 10:48 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100		472,727	472,727	-184,526	288,201	1.00
2.00	00200		0	0	351,751	351,751	2.00
3.00	00300		0	0	0	0	3.00
4.00	00400	80,463	1,384,676	1,465,139	0	1,465,139	4.00
5.00	00500	1,264,916	1,962,575	3,227,491	817	3,228,308	5.00
6.00	00600	199,553	92,449	292,002	0	292,002	6.00
7.00	00700	0	165,857	165,857	249	166,106	7.00
8.00	00800	53,677	12,540	66,217	0	66,217	8.00
9.00	00900	164,301	24,622	188,923	0	188,923	9.00
10.00	01000	179,026	141,131	320,157	-147,839	172,318	10.00
11.00	01100	0	0	0	147,839	147,839	11.00
13.00	01300	142,475	2,654	145,129	0	145,129	13.00
16.00	01600	246,806	26,590	273,396	0	273,396	16.00
19.00	01900	0	208,000	208,000	0	208,000	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,159,349	34,139	1,193,488	0	1,193,488	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	161,044	100,977	262,021	0	262,021	50.00
53.00	05300	0	6,021	6,021	0	6,021	53.00
54.00	05400	407,407	508,053	915,460	30,272	945,732	54.00
60.00	06000	395,667	465,271	860,938	2,916	863,854	60.00
65.00	06500	284,128	25,173	309,301	0	309,301	65.00
66.00	06600	7,324	439,289	446,613	-7,468	439,145	66.00
71.00	07100	0	129,109	129,109	0	129,109	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	167,979	531,373	699,352	0	699,352	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	1,333,052	183,882	1,516,934	34,408	1,551,342	88.00
90.00	09000	151,856	38,130	189,986	0	189,986	90.00
91.00	09100	412,461	1,022,550	1,435,011	6,000	1,441,011	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300		205,025	205,025	-205,025	0	113.00
118.00		6,811,484	8,182,813	14,994,297	29,394	15,023,691	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	1,568	924	2,492	0	2,492	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
194.00	07950	0	46,051	46,051	-29,394	16,657	194.00
194.01	07951	0	101,517	101,517	0	101,517	194.01
200.00		6,813,052	8,331,305	15,144,357	0	15,144,357	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 141324

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

Worksheet A
Date/Time Prepared:
8/26/2015 10:48 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-619	287,582	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-64,514	287,237	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-14,499	1,450,640	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-445,395	2,782,913	5.00
6.00	00600	MAINTENANCE & REPAIRS	-318	291,684	6.00
7.00	00700	OPERATION OF PLANT	-3,525	162,581	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	66,217	8.00
9.00	00900	HOUSEKEEPING	0	188,923	9.00
10.00	01000	DIETARY	0	172,318	10.00
11.00	01100	CAFETERIA	-27,874	119,965	11.00
13.00	01300	NURSING ADMINISTRATION	0	145,129	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-18,619	254,777	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	208,000	19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	1,193,488	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	262,021	50.00
53.00	05300	ANESTHESIOLOGY	0	6,021	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-182	945,550	54.00
60.00	06000	LABORATORY	-13	863,841	60.00
65.00	06500	RESPIRATORY THERAPY	0	309,301	65.00
66.00	06600	PHYSICAL THERAPY	0	439,145	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	129,109	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,710	697,642	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	-75,937	1,475,405	88.00
90.00	09000	CLINIC	0	189,986	90.00
91.00	09100	EMERGENCY	0	1,441,011	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-653,205	14,370,486	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	2,492	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	192.02
194.00	07950	MARKETING	0	16,657	194.00
194.01	07951	NONREIMBURSABLE COST CENTER	0	101,517	194.01
200.00		TOTAL (SUM OF LINES 118-199)	-653,205	14,491,152	200.00

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
A - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	82,669	65,170	1.00
	O		82,669	65,170	
B - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	143,120	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	21,809	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	30,272	3.00
4.00	LABORATORY	60.00	0	2,916	4.00
5.00	RURAL HEALTH CLINIC	88.00	0	6,908	5.00
	O		0	205,025	
C - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11,828	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	12,277	2.00
	O		0	24,105	
E - MARKETING & ADVERTISING					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	29,394	1.00
	O		0	29,394	
K - MME DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	339,474	1.00
	O		0	339,474	
L - UTILITIES FOR RENTAL SPACE					
1.00	PHYSICAL THERAPY	66.00	0	975	1.00
	O		0	975	
M - ADMIN RECRUITING					
1.00	EMERGENCY	91.00	0	6,000	1.00
2.00	RURAL HEALTH CLINIC	88.00	27,500	0	2.00
	O		27,500	6,000	
N - PHYSICAL THERAPY RENT AND UTILITIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	7,219	1.00
2.00	OPERATION OF PLANT	7.00	0	1,224	2.00
	O		0	8,443	
500.00	Grand Total: Increases		110,169	678,586	500.00

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA COSTS							
1.00	DIETARY	10.00	82,669	65,170	0		1.00
	O		82,669	65,170			
B - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	205,025	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	O		0	205,025			
C - PROPERTY INSURANCE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	24,105	12		1.00
2.00		0.00	0	0	12		2.00
	O		0	24,105			
E - MARKETING & ADVERTISING							
1.00	MARKETING	194.00	0	29,394	0		1.00
	O		0	29,394			
K - MME DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	339,474	9		1.00
	O		0	339,474			
L - UTILITIES FOR RENTAL SPACE							
1.00	OPERATION OF PLANT	7.00	0	975	0		1.00
	O		0	975			
M - ADMIN RECRUITING							
1.00	ADMINISTRATIVE & GENERAL	5.00	27,500	6,000	0		1.00
2.00		0.00	0	0	0		2.00
	O		27,500	6,000			
N - PHYSICAL THERAPY RENT AND UTILITIES							
1.00	PHYSICAL THERAPY	66.00	0	8,443	0		1.00
2.00		0.00	0	0	0		2.00
	O		0	8,443			
500.00	Grand Total: Decreases		110,169	678,586			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141324

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

Worksheet A-7
Part I
Date/Time Prepared:
8/26/2015 10:48 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	159,712	0	0	0	1.00
2.00	Land Improvements	44,285	0	0	0	2.00
3.00	Buildings and Fixtures	2,885,878	8,117	0	8,117	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	632,541	0	0	0	5.00
6.00	Movable Equipment	2,381,227	64,779	0	64,779	6.00
7.00	HIT designated Assets	1,139,108	287,090	0	287,090	7.00
8.00	Subtotal (sum of lines 1-7)	7,242,751	359,986	0	359,986	8.00
9.00	Reconciling Items	0	-11,568	0	-11,568	-1 9.00
10.00	Total (line 8 minus line 9)	7,242,751	371,554	0	371,554	1 10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	159,712	0			1.00
2.00	Land Improvements	44,285	0			2.00
3.00	Buildings and Fixtures	2,893,995	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	632,541	0			5.00
6.00	Movable Equipment	2,446,006	0			6.00
7.00	HIT designated Assets	1,426,198	0			7.00
8.00	Subtotal (sum of lines 1-7)	7,602,737	0			8.00
9.00	Reconciling Items	-11,567	0			9.00
10.00	Total (line 8 minus line 9)	7,614,304	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141324

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

Worksheet A-7
Part II
Date/Time Prepared:
8/26/2015 10:48 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	472,727	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	472,727	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	472,727				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	472,727				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 141324

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

Worksheet A-7
Part III
Date/Time Prepared:
8/26/2015 10:48 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	3,730,533	0	3,730,533	0.490683	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,872,204	0	3,872,204	0.509317	0	2.00
3.00	Total (sum of lines 1-2)	7,602,737	0	7,602,737	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of col. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	133,253	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	274,960	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	408,213	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of col. 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	142,501	11,828	0	0	287,582	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	12,277	0	0	287,237	2.00
3.00	Total (sum of lines 1-2)	142,501	24,105	0	0	574,819	3.00

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
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-619	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)	B	-5,487	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-1,100	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)	A	-6,501	ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-283			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-27,874	CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others	B	-5,100	RURAL HEALTH CLINIC	88.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients	B	-1,575	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00 Sale of medical records and abstracts	B	-18,619	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant		0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00

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
32.00 CAH HIT Adjustment for Depreciation and Interest	A	-63,053	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00 SALE OF XRAY	B	-51	RADIOLOGY-DIAGNOSTIC	54.00	0	33.00
33.01 MED INCENTIVE REVENUE	B	-200	ADMINISTRATIVE & GENERAL	5.00	0	33.01
33.02 RECYCLING INCOME	B	-318	MAINTENANCE & REPAIRS	6.00	0	33.02
33.03 FLUE SHOTS AT FESTIVAL	B	-135	DRUGS CHARGED TO PATIENTS	73.00	0	33.03
33.04 EMPLOYEE REIMBURSEMENT	B	-25	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.04
33.05 OTHER MISC. RECEIPTS	B	-110	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 ROTARY DUES	B	-23	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 PONTON HOUSE RENTAL INCOME	B	-1,725	OPERATION OF PLANT	7.00	0	33.07
33.08 PROPERTY TAX REFUND	B	-21,601	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09		0		0.00	0	33.09
33.10 INTEREST INCOME OFFSET	B	-94	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33.11 INTEREST INCOME OFFSET	B	-131	RADIOLOGY-DIAGNOSTIC	54.00	0	33.11
33.12 INTEREST INCOME OFFSET	B	-13	LABORATORY	60.00	0	33.12
33.13 INTEREST INCOME OFFSET	B	-30	RURAL HEALTH CLINIC	88.00	0	33.13
33.14 PROVIDER TAX	A	-378,593	ADMINISTRATIVE & GENERAL	5.00	0	33.14
33.15 J HOHENBERGER TEMP HOUSING RENTAL IN	B	-1,500	OPERATION OF PLANT	7.00	0	33.15
33.16 ADVERTISING COSTS	A	-23,456	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.17 DEACONESS OFFICE SPACE FOR LIASON RE	B	-300	OPERATION OF PLANT	7.00	0	33.17
33.18 TELEPHONE - DEPRECIATION	A	-1,461	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.18
33.19 TELEPHONE - OPERATOR WAGES	A	-385	ADMINISTRATIVE & GENERAL	5.00	0	33.19
33.20 TELEPHONE - OPERATOR BENEFITS	A	-83	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.20
33.21 LOBBYING PORTION OF DUES	A	-7,449	ADMINISTRATIVE & GENERAL	5.00	0	33.21
33.22 FINES & FEES	A	-113	ADMINISTRATIVE & GENERAL	5.00	0	33.22
33.23		0		0.00	0	33.23
33.24 NON-RHC PROVIDER SALARIES	A	-70,807	RURAL HEALTH CLINIC	88.00	0	33.24
33.25 NON-RHC PROVIDER BENEFITS	A	-14,391	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.25
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-653,205				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: 141324

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

Worksheet A-8-2

Date/Time Prepared:
8/26/2015 10:48 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	283	283	0	0	0	1.00
2.00	91.00	EMERGENCY	999,000	0	999,000	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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			999,283	283	999,000	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		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	5.00	ADMINISTRATIVE & GENERAL	0	0	0	283	1.00
2.00	91.00	EMERGENCY	0	0	0	0	2.00
3.00	0.00		0	0	0	0	3.00
4.00	0.00		0	0	0	0	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	283	200.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141324		Period: From 04/01/2014 To 03/31/2015		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/26/2015 10:48 am	
				Physical Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					347	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.64	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	1,832.00	1,246.00	1,242.00	3.00	0.00	9.00
10.00	AHSEA (see instructions)	76.58	76.58	57.44	38.29	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38.29	38.29	28.72			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					140,295	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					95,419	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					71,340	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					307,054	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					115	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					307,169	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					307,169	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					13,287	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					13,287	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,957	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					15,244	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					15,244	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141324				Period: From 04/01/2014 To 03/31/2015		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/26/2015 10:48 am	
							Physical Therapy	Cost	
							1.00		
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0	46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	0.00	47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00	0.00	48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00	0.00	49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	0.00	50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	76.58	57.44	38.29	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	0	56.00	
							1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)						307,169	57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))						15,244	58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)						0	59.00	
60.00	Overtime allowance (from column 5, line 56)						0	60.00	
61.00	Equipment cost (see instructions)						0	61.00	
62.00	Supplies (see instructions)						0	62.00	
63.00	Total allowance (sum of lines 57-62)						322,413	63.00	
64.00	Total cost of outside supplier services (from your records)						207,458	64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)						0	65.00	
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						13,287	100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,957	100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27						15,244	100.02	
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						1,957	101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	101.01	
101.02	Line 34 = sum of lines 27 and 31						1,957	101.02	
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						0	102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						0	102.01	
102.02	Line 35 = sum of lines 31 and 32						0	102.02	

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141324		Period: From 04/01/2014 To 03/31/2015		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/26/2015 10:48 am	
				Occupational Therapy		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					52	1.00
2.00	Line 1 multiplied by 15 hours per week					780	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					253	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.64	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	1,792.00	629.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	72.58	54.43	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	36.29	36.29	27.22			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					130,063	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					34,236	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					164,299	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					164,299	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					0.00	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					0	22.00
23.00	Total salary equivalency (see instructions)					164,299	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					9,181	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					9,181	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					1,427	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					10,608	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					10,608	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141324		Period: From 04/01/2014 To 03/31/2015		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/26/2015 10:48 am	
				Occupational Therapy		Cost	
						1.00	
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00
46.00	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)					0	46.00
		Therapists	Assistants	Aides	Trainees	Total	
		1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION							
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
CALCULATION OF LIMIT							
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE							
52.00	Adjusted hourly salary equivalency amount (see instructions)	72.58	54.43	0.00	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0		55.00
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0	56.00
						1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT							
57.00	Salary equivalency amount (from line 23)					164,299	57.00
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					10,608	58.00
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0	59.00
60.00	Overtime allowance (from column 5, line 56)					0	60.00
61.00	Equipment cost (see instructions)					0	61.00
62.00	Supplies (see instructions)					0	62.00
63.00	Total allowance (sum of lines 57-62)					174,907	63.00
64.00	Total cost of outside supplier services (from your records)					94,765	64.00
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0	65.00
LINE 33 CALCULATION							
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					9,181	100.00
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,427	100.01
100.02	Line 33 = line 28 = sum of lines 26 and 27					10,608	100.02
LINE 34 CALCULATION							
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					1,427	101.00
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						101.01
101.02	Line 34 = sum of lines 27 and 31					1,427	101.02
LINE 35 CALCULATION							
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others						102.00
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others						102.01
102.02	Line 35 = sum of lines 31 and 32						102.02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141324		Period: From 04/01/2014 To 03/31/2015		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/26/2015 10:48 am	
				Speech Pathology		Cost	
						1.00	
PART I - GENERAL INFORMATION							
1.00	Total number of weeks worked (excluding aides) (see instructions)					39	1.00
2.00	Line 1 multiplied by 15 hours per week					585	2.00
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)					77	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)					0	4.00
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)					0	5.00
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	6.00
7.00	Standard travel expense rate					5.64	7.00
8.00	Optional travel expense rate per mile					0.00	8.00
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1.00	2.00	3.00	4.00	5.00	
9.00	Total hours worked	0.00	108.00	0.00	0.00	0.00	9.00
10.00	AHSEA (see instructions)	0.00	69.74	0.00	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	34.87	34.87	0.00			11.00
12.00	Number of travel hours (provider site)	0	0	0			12.00
12.01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	0	0	0			13.00
13.01	Number of miles driven (offsite)	0	0	0			13.01
						1.00	
Part II - SALARY EQUIVALENCY COMPUTATION							
14.00	Supervisors (column 1, line 9 times column 1, line 10)					0	14.00
15.00	Therapists (column 2, line 9 times column 2, line 10)					7,532	15.00
16.00	Assistants (column 3, line 9 times column 3, line 10)					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					7,532	17.00
18.00	Aides (column 4, line 9 times column 4, line 10)					0	18.00
19.00	Trainees (column 5, line 9 times column 5, line 10)					0	19.00
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)					7,532	20.00
If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)					69.74	21.00
22.00	Weighted allowance excluding aides and trainees (line 2 times line 21)					40,798	22.00
23.00	Total salary equivalency (see instructions)					40,798	23.00
PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
Standard Travel Allowance							
24.00	Therapists (line 3 times column 2, line 11)					2,685	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)					2,685	26.00
27.00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)					434	27.00
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)					3,119	28.00
Optional Travel Allowance and Optional Travel Expense							
29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)					0	29.00
30.00	Assistants (column 3, line 10 times column 3, line 12)					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)					0	31.00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)					0	32.00
33.00	Standard travel allowance and standard travel expense (line 28)					3,119	33.00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)					0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)					0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE							
Standard Travel Expense							
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)					0	39.00
Optional Travel Allowance and Optional Travel Expense							
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)					0	40.00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)					0	41.00
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)					0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.							
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)					0	44.00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)					0	45.00

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS		Provider CCN: 141324				Period: From 04/01/2014 To 03/31/2015		Worksheet A-8-3 Parts I-VI Date/Time Prepared: 8/26/2015 10:48 am	
		Speech Pathology				Cost			
						1.00			
46.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)						0		46.00	
		Therapists	Assistants	Aides	Trainees	Total			
		1.00	2.00	3.00	4.00	5.00			
PART V - OVERTIME COMPUTATION									
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00		47.00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00	0.00		48.00	
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00	0.00		49.00	
CALCULATION OF LIMIT									
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00		50.00	
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00		51.00	
DETERMINATION OF OVERTIME ALLOWANCE									
52.00	Adjusted hourly salary equivalency amount (see instructions)	69.74	0.00	0.00	0.00			52.00	
53.00	Overtime cost limitation (line 51 times line 52)	0	0	0	0			53.00	
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0	0	0			54.00	
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	0	0			55.00	
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	0	0	0		56.00	
						1.00			
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT									
57.00	Salary equivalency amount (from line 23)					40,798		57.00	
58.00	Travel allowance and expense - provider site (from lines 33, 34, or 35))					3,119		58.00	
59.00	Travel allowance and expense - Offsite services (from lines 44, 45, or 46)					0		59.00	
60.00	Overtime allowance (from column 5, line 56)					0		60.00	
61.00	Equipment cost (see instructions)					0		61.00	
62.00	Supplies (see instructions)					0		62.00	
63.00	Total allowance (sum of lines 57-62)					43,917		63.00	
64.00	Total cost of outside supplier services (from your records)					6,177		64.00	
65.00	Excess over limitation (line 64 minus line 63 - if negative, enter zero)					0		65.00	
LINE 33 CALCULATION									
100.00	Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others					2,685		100.00	
100.01	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					434		100.01	
100.02	Line 33 = line 28 = sum of lines 26 and 27					3,119		100.02	
LINE 34 CALCULATION									
101.00	Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others					434		101.00	
101.01	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		101.01	
101.02	Line 34 = sum of lines 27 and 31					434		101.02	
LINE 35 CALCULATION									
102.00	Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0		102.00	
102.01	Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others					0		102.01	
102.02	Line 35 = sum of lines 31 and 32					0		102.02	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141324

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

Worksheet B
Part I
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Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	287,582	287,582			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	287,237		287,237		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	1,450,640	2,378	2,376	1,455,394	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	2,782,913	69,215	69,133	264,261	3,185,522
6.00 00600	MAINTENANCE & REPAIRS	291,684	10,571	10,558	43,599	356,412
7.00 00700	OPERATION OF PLANT	162,581	12,215	12,200	0	186,996
8.00 00800	LAUNDRY & LINEN SERVICE	66,217	7,789	7,779	11,727	93,512
9.00 00900	HOUSEKEEPING	188,923	1,637	1,635	35,897	228,092
10.00 01000	DIETARY	172,318	10,453	10,441	2,991	196,203
11.00 01100	CAFETERIA	119,965	4,236	4,231	36,123	164,555
13.00 01300	NURSING ADMINISTRATION	145,129	2,834	2,830	31,128	181,921
16.00 01600	MEDICAL RECORDS & LIBRARY	254,777	11,929	11,914	53,923	332,543
19.00 01900	NONPHYSICIAN ANESTHETISTS	208,000	0	0	0	208,000
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1,193,488	35,595	35,553	253,297	1,517,933
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	262,021	16,355	16,336	35,185	329,897
53.00 05300	ANESTHESIOLOGY	6,021	0	0	0	6,021
54.00 05400	RADIOLOGY-DIAGNOSTIC	945,550	18,183	18,161	89,011	1,070,905
60.00 06000	LABORATORY	863,841	9,301	9,290	86,446	968,878
65.00 06500	RESPIRATORY THERAPY	309,301	13,779	13,762	62,077	398,919
66.00 06600	PHYSICAL THERAPY	439,145	0	0	1,600	440,745
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	129,109	0	0	0	129,109
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	697,642	5,043	5,037	36,700	744,422
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	1,475,405	35,015	34,973	287,793	1,833,186
90.00 09000	CLINIC	189,986	10,916	10,903	33,178	244,983
91.00 09100	EMERGENCY	1,441,011	10,138	10,125	90,115	1,551,389
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	14,370,486	287,582	287,237	1,455,051	14,370,143
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	2,492	0	0	343	2,835
192.01 19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.02 19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	MARKETING	16,657	0	0	0	16,657
194.01 07951	NONREIMBURSABLE COST CENTER	101,517	0	0	0	101,517
200.00	Cross Foot Adjustments					0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	14,491,152	287,582	287,237	1,455,394	14,491,152

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141324

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

Worksheet B
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	3,185,522				5.00	
6.00	00600	MAINTENANCE & REPAIRS	100,424	456,836			6.00	
7.00	00700	OPERATION OF PLANT	52,689	26,388	266,073		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	26,348	15,158	10,726	145,744	8.00	
9.00	00900	HOUSEKEEPING	64,268	3,557	2,254	35,734	333,905	9.00
10.00	01000	DIETARY	55,283	20,344	14,396	1,136	16,499	10.00
11.00	01100	CAFETERIA	46,366	11,144	5,833	0	9,037	11.00
13.00	01300	NURSING ADMINISTRATION	51,259	5,515	3,902	0	4,472	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	93,699	23,216	16,428	0	18,828	16.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	58,607	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	427,699	69,277	49,022	73,295	56,182	30.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	92,953	31,831	22,524	4,736	25,814	50.00
53.00	05300	ANESTHESIOLOGY	1,697	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	301,742	35,389	25,041	10,032	28,699	54.00
60.00	06000	LABORATORY	272,995	21,245	12,809	104	17,229	60.00
65.00	06500	RESPIRATORY THERAPY	112,401	26,816	18,976	202	21,747	65.00
66.00	06600	PHYSICAL THERAPY	124,186	15,673	0	3,105	12,710	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	36,378	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	209,751	9,815	6,945	0	7,960	73.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	516,528	100,493	48,223	904	81,498	88.00
90.00	09000	CLINIC	69,027	21,245	15,033	132	17,229	90.00
91.00	09100	EMERGENCY	437,126	19,730	13,961	16,364	16,001	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,151,426	456,836	266,073	145,744	333,905	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	799	0	0	0	0	192.00
192.01	19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.01
192.02	19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.02
194.00	07950	MARKETING	4,693	0	0	0	0	194.00
194.01	07951	NONREIMBURSABLE COST CENTER	28,604	0	0	0	0	194.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,185,522	456,836	266,073	145,744	333,905	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141324

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

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Part I
Date/Time Prepared:
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		10.00	11.00	13.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	303,861					10.00
11.00	01100	0	236,935				11.00
13.00	01300	0	8,270	255,339			13.00
16.00	01600	0	18,550	0	503,264		16.00
19.00	01900	0	0	0	0	266,607	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	303,861	70,003	182,069	50,582		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	7,573	19,696	22,165	0	50.00
53.00	05300	0	0	0	13,476	266,607	53.00
54.00	05400	0	20,383	0	118,870	0	54.00
60.00	06000	0	26,320	0	90,406	0	60.00
65.00	06500	0	13,368	5,536	18,148	0	65.00
66.00	06600	0	0	0	24,403	0	66.00
71.00	07100	0	0	0	19,573	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	7,511	19,534	42,093	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	45,060	0	45,731	0	88.00
90.00	09000	0	8,937	0	15,180	0	90.00
91.00	09100	0	10,960	28,504	42,637	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		303,861	236,935	255,339	503,264	266,607	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		303,861	236,935	255,339	503,264	266,607	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 141324

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
16.00	01600				16.00
19.00	01900				19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	2,799,923	0	2,799,923	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	557,189	0	557,189	50.00
53.00	05300	287,801	0	287,801	53.00
54.00	05400	1,611,061	0	1,611,061	54.00
60.00	06000	1,409,986	0	1,409,986	60.00
65.00	06500	616,113	0	616,113	65.00
66.00	06600	620,822	0	620,822	66.00
71.00	07100	185,060	0	185,060	71.00
72.00	07200	0	0	0	72.00
73.00	07300	1,048,031	0	1,048,031	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	2,671,623	0	2,671,623	88.00
90.00	09000	391,766	0	391,766	90.00
91.00	09100	2,136,672	0	2,136,672	91.00
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		14,336,047	0	14,336,047	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	3,634	0	3,634	192.00
192.01	19201	0	0	0	192.01
192.02	19202	0	0	0	192.02
194.00	07950	21,350	0	21,350	194.00
194.01	07951	130,121	0	130,121	194.01
200.00		0	0	0	200.00
201.00		0	0	0	201.00
202.00		14,491,152	0	14,491,152	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141324

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	2,378	2,376	4,754	4,754
5.00 00500	ADMINISTRATIVE & GENERAL	0	69,215	69,133	138,348	864
6.00 00600	MAINTENANCE & REPAIRS	0	10,571	10,558	21,129	142
7.00 00700	OPERATION OF PLANT	0	12,215	12,200	24,415	0
8.00 00800	LAUNDRY & LINEN SERVICE	0	7,789	7,779	15,568	38
9.00 00900	HOUSEKEEPING	0	1,637	1,635	3,272	117
10.00 01000	DIETARY	0	10,453	10,441	20,894	10
11.00 01100	CAFETERIA	0	4,236	4,231	8,467	118
13.00 01300	NURSING ADMINISTRATION	0	2,834	2,830	5,664	102
16.00 01600	MEDICAL RECORDS & LIBRARY	0	11,929	11,914	23,843	176
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	35,595	35,553	71,148	828
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	16,355	16,336	32,691	115
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	18,183	18,161	36,344	291
60.00 06000	LABORATORY	0	9,301	9,290	18,591	283
65.00 06500	RESPIRATORY THERAPY	0	13,779	13,762	27,541	203
66.00 06600	PHYSICAL THERAPY	0	0	0	0	5
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	5,043	5,037	10,080	120
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	35,015	34,973	69,988	939
90.00 09000	CLINIC	0	10,916	10,903	21,819	108
91.00 09100	EMERGENCY	0	10,138	10,125	20,263	294
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	287,582	287,237	574,819	4,753
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	1
192.01 19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.02 19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	MARKETING	0	0	0	0	0
194.01 07951	NONREIMBURSABLE COST CENTER	0	0	0	0	0
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	0	287,582	287,237	574,819	4,754

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141324

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

Worksheet B
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500	139,212					5.00
6.00	00600	4,389	25,660				6.00
7.00	00700	2,303	1,482	28,200			7.00
8.00	00800	1,152	851	1,137	18,746		8.00
9.00	00900	2,809	200	239	4,596	11,233	9.00
10.00	01000	2,416	1,143	1,526	146	555	10.00
11.00	01100	2,026	626	618	0	304	11.00
13.00	01300	2,240	310	414	0	150	13.00
16.00	01600	4,095	1,304	1,741	0	633	16.00
19.00	01900	2,561	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	18,692	3,891	5,195	9,429	1,890	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	4,062	1,788	2,387	609	868	50.00
53.00	05300	74	0	0	0	0	53.00
54.00	05400	13,187	1,988	2,654	1,290	965	54.00
60.00	06000	11,931	1,193	1,358	13	580	60.00
65.00	06500	4,912	1,506	2,011	26	732	65.00
66.00	06600	5,427	880	0	399	428	66.00
71.00	07100	1,590	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	9,167	551	736	0	268	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	22,568	5,646	5,111	116	2,742	88.00
90.00	09000	3,017	1,193	1,593	17	580	90.00
91.00	09100	19,104	1,108	1,480	2,105	538	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		137,722	25,660	28,200	18,746	11,233	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	35	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
194.00	07950	205	0	0	0	0	194.00
194.01	07951	1,250	0	0	0	0	194.01
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		139,212	25,660	28,200	18,746	11,233	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 141324		Period: From 04/01/2014 To 03/31/2015		Worksheet B Part II Date/Time Prepared: 8/26/2015 10:48 am	
Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	NONPHYSICIAN ANESTHETISTS	
		10.00	11.00	13.00	16.00	19.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	26,690					10.00
11.00	01100	0	12,159				11.00
13.00	01300	0	424	9,304			13.00
16.00	01600	0	952	0	32,744		16.00
19.00	01900	0	0	0	0	2,561	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	26,690	3,593	6,633	3,292		30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	389	718	1,442		50.00
53.00	05300	0	0	0	877		53.00
54.00	05400	0	1,046	0	7,728		54.00
60.00	06000	0	1,351	0	5,884		60.00
65.00	06500	0	686	202	1,181		65.00
66.00	06600	0	0	0	1,588		66.00
71.00	07100	0	0	0	1,274		71.00
72.00	07200	0	0	0	0		72.00
73.00	07300	0	385	712	2,739		73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	2,312	0	2,976		88.00
90.00	09000	0	459	0	988		90.00
91.00	09100	0	562	1,039	2,775		91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		26,690	12,159	9,304	32,744	0	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0		192.00
192.01	19201	0	0	0	0		192.01
192.02	19202	0	0	0	0		192.02
194.00	07950	0	0	0	0		194.00
194.01	07951	0	0	0	0		194.01
200.00						2,561	200.00
201.00		0	0	0	0	0	201.00
202.00		26,690	12,159	9,304	32,744	2,561	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 141324

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

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					
1.00	00100				1.00
2.00	00200				2.00
4.00	00400				4.00
5.00	00500				5.00
6.00	00600				6.00
7.00	00700				7.00
8.00	00800				8.00
9.00	00900				9.00
10.00	01000				10.00
11.00	01100				11.00
13.00	01300				13.00
16.00	01600				16.00
19.00	01900				19.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	151,281	0	151,281	30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	45,069	0	45,069	50.00
53.00	05300	951	0	951	53.00
54.00	05400	65,493	0	65,493	54.00
60.00	06000	41,184	0	41,184	60.00
65.00	06500	39,000	0	39,000	65.00
66.00	06600	8,727	0	8,727	66.00
71.00	07100	2,864	0	2,864	71.00
72.00	07200	0	0	0	72.00
73.00	07300	24,758	0	24,758	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	112,398	0	112,398	88.00
90.00	09000	29,774	0	29,774	90.00
91.00	09100	49,268	0	49,268	91.00
92.00	09200		0		92.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300				113.00
118.00		570,767	0	570,767	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	36	0	36	192.00
192.01	19201	0	0	0	192.01
192.02	19202	0	0	0	192.02
194.00	07950	205	0	205	194.00
194.01	07951	1,250	0	1,250	194.01
200.00		2,561	0	2,561	200.00
201.00		0	0	0	201.00
202.00		574,819	0	574,819	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141324

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	39,176				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		39,176			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	324	324	6,661,397		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	9,429	9,429	1,209,531	-3,185,522	11,305,630
6.00 00600	MAINTENANCE & REPAIRS	1,440	1,440	199,553	0	356,412
7.00 00700	OPERATION OF PLANT	1,664	1,664	0	0	186,996
8.00 00800	LAUNDRY & LINEN SERVICE	1,061	1,061	53,677	0	93,512
9.00 00900	HOUSEKEEPING	223	223	164,301	0	228,092
10.00 01000	DIETARY	1,424	1,424	13,688	0	196,203
11.00 01100	CAFETERIA	577	577	165,338	0	164,555
13.00 01300	NURSING ADMINISTRATION	386	386	142,475	0	181,921
16.00 01600	MEDICAL RECORDS & LIBRARY	1,625	1,625	246,806	0	332,543
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	208,000
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	4,849	4,849	1,159,349	0	1,517,933
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	2,228	2,228	161,044	0	329,897
53.00 05300	ANESTHESIOLOGY	0	0	0	0	6,021
54.00 05400	RADIOLOGY-DIAGNOSTIC	2,477	2,477	407,407	0	1,070,905
60.00 06000	LABORATORY	1,267	1,267	395,667	0	968,878
65.00 06500	RESPIRATORY THERAPY	1,877	1,877	284,128	0	398,919
66.00 06600	PHYSICAL THERAPY	0	0	7,324	0	440,745
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	129,109
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	687	687	167,979	0	744,422
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	4,770	4,770	1,317,245	0	1,833,186
90.00 09000	CLINIC	1,487	1,487	151,856	0	244,983
91.00 09100	EMERGENCY	1,381	1,381	412,461	0	1,551,389
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
118.00	SUBTOTALS (SUM OF LINES 1-117)	39,176	39,176	6,659,829	-3,185,522	11,184,621
NONREIMBURSABLE COST CENTERS						
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	1,568	0	2,835
192.01 19201	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
192.02 19202	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
194.00 07950	MARKETING	0	0	0	0	16,657
194.01 07951	NONREIMBURSABLE COST CENTER	0	0	0	0	101,517
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	287,582	287,237	1,455,394		3,185,522
203.00	Unit cost multiplier (Wkst. B, Part I)	7.340770	7.331963	0.218482		0.281764
204.00	Cost to be allocated (per Wkst. B, Part II)			4,754		139,212
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000714		0.012314

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141324

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	31,976					6.00
7.00	00700	1,847	26,319				7.00
8.00	00800	1,061	1,061	77,362			8.00
9.00	00900	249	223	18,968	28,819		9.00
10.00	01000	1,424	1,424	603	1,424	2,175	10.00
11.00	01100	780	577	0	780	0	11.00
13.00	01300	386	386	0	386	0	13.00
16.00	01600	1,625	1,625	0	1,625	0	16.00
19.00	01900	0	0	0	0	0	19.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,849	4,849	38,906	4,849	2,175	30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	2,228	2,228	2,514	2,228	0	50.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	2,477	2,477	5,325	2,477	0	54.00
60.00	06000	1,487	1,267	55	1,487	0	60.00
65.00	06500	1,877	1,877	107	1,877	0	65.00
66.00	06600	1,097	0	1,648	1,097	0	66.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	687	687	0	687	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	7,034	4,770	480	7,034	0	88.00
90.00	09000	1,487	1,487	70	1,487	0	90.00
91.00	09100	1,381	1,381	8,686	1,381	0	91.00
92.00	09200						92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		31,976	26,319	77,362	28,819	2,175	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	0	0	0	0	0	192.00
192.01	19201	0	0	0	0	0	192.01
192.02	19202	0	0	0	0	0	192.02
194.00	07950	0	0	0	0	0	194.00
194.01	07951	0	0	0	0	0	194.01
200.00							200.00
201.00							201.00
202.00		456,836	266,073	145,744	333,905	303,861	202.00
203.00		14,286,840	10,109,541	1,883,922	11,586,280	139,706,207	203.00
204.00		25,660	28,200	18,746	11,233	26,690	204.00
205.00		0.802477	1.071469	0.242315	0.389778	12.271264	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 141324

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	
		11.00	13.00	16.00	19.00	
GENERAL SERVICE COST CENTERS						
1.00	00100					1.00
2.00	00200					2.00
4.00	00400					4.00
5.00	00500					5.00
6.00	00600					6.00
7.00	00700					7.00
8.00	00800					8.00
9.00	00900					9.00
10.00	01000					10.00
11.00	01100	190,226				11.00
13.00	01300	6,640	78,821			13.00
16.00	01600	14,893	0	36,430,789		16.00
19.00	01900	0	0	0	100	19.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	56,203	56,203	3,661,655		30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	6,080	6,080	1,604,559	0	50.00
53.00	05300	0	0	975,509	100	53.00
54.00	05400	16,365	0	8,604,338	0	54.00
60.00	06000	21,131	0	6,544,516	0	60.00
65.00	06500	10,733	1,709	1,313,757	0	65.00
66.00	06600	0	0	1,766,542	0	66.00
71.00	07100	0	0	1,416,886	0	71.00
72.00	07200	0	0	0	0	72.00
73.00	07300	6,030	6,030	3,047,128	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	36,177	0	3,310,468	0	88.00
90.00	09000	7,175	0	1,098,899	0	90.00
91.00	09100	8,799	8,799	3,086,532	0	91.00
92.00	09200					92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300					113.00
118.00		190,226	78,821	36,430,789	100	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	0	0	0	0	192.00
192.01	19201	0	0	0	0	192.01
192.02	19202	0	0	0	0	192.02
194.00	07950	0	0	0	0	194.00
194.01	07951	0	0	0	0	194.01
200.00						200.00
201.00						201.00
202.00		236,935	255,339	503,264	266,607	202.00
203.00		1.245545	3.239479	0.013814	2,666.070000	203.00
204.00		12,159	9,304	32,744	2,561	204.00
205.00		0.063919	0.118040	0.000899	25.610000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141324

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

Worksheet C
Part I
Date/Time Prepared:
8/26/2015 10:48 am

		Title XVIII		Hospital		Cost
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2,799,923		2,799,923	0	0 30.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	557,189		557,189	0	0 50.00
53.00	05300 ANESTHESIOLOGY	287,801		287,801	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1,611,061		1,611,061	0	0 54.00
60.00	06000 LABORATORY	1,409,986		1,409,986	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	616,113	0	616,113	0	0 65.00
66.00	06600 PHYSICAL THERAPY	620,822	0	620,822	0	0 66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	185,060		185,060	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,048,031		1,048,031	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	2,671,623		2,671,623	0	0 88.00
90.00	09000 CLINIC	391,766		391,766	0	0 90.00
91.00	09100 EMERGENCY	2,136,672		2,136,672	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	368,775		368,775	0	0 92.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	14,704,822	0	14,704,822	0	0 200.00
201.00	Less Observation Beds	368,775		368,775		0 201.00
202.00	Total (see instructions)	14,336,047	0	14,336,047	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 141324

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

Worksheet C
Part I
Date/Time Prepared:
8/26/2015 10:48 am

Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
		Title VIII			Hospital	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	3,192,152		3,192,152			30.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	70,986	1,533,573	1,604,559	0.347254	0.000000	50.00
53.00	05300 ANESTHESIOLOGY	33,014	942,495	975,509	0.295026	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	645,408	7,958,930	8,604,338	0.187238	0.000000	54.00
60.00	06000 LABORATORY	833,953	5,710,563	6,544,516	0.215445	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	582,854	730,903	1,313,757	0.468970	0.000000	65.00
66.00	06600 PHYSICAL THERAPY	354,877	1,411,665	1,766,542	0.351433	0.000000	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	841,707	575,179	1,416,886	0.130610	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,506,944	1,540,184	3,047,128	0.343941	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	3,310,468	3,310,468			88.00
90.00	09000 CLINIC	0	1,098,899	1,098,899	0.356508	0.000000	90.00
91.00	09100 EMERGENCY	85,661	3,000,871	3,086,532	0.692257	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	44,655	424,848	469,503	0.785458	0.000000	92.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	8,192,211	28,238,578	36,430,789			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	8,192,211	28,238,578	36,430,789			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet C Part I Date/Time Prepared: 8/26/2015 10:48 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital Cost
		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
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
90.00	09000 CLINIC	0.000000		90.00
91.00	09100 EMERGENCY	0.000000		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
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: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet D Part II Date/Time Prepared: 8/26/2015 10:48 am
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Cost Center Description		Capital Related Cost (from Wkst. C, 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	45,069	1,604,559	0.028088	38,927	1,093	50.00
53.00	05300 ANESTHESIOLOGY	951	975,509	0.000975	14,485	14	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	65,493	8,604,338	0.007612	338,142	2,574	54.00
60.00	06000 LABORATORY	41,184	6,544,516	0.006293	486,655	3,063	60.00
65.00	06500 RESPIRATORY THERAPY	39,000	1,313,757	0.029686	353,668	10,499	65.00
66.00	06600 PHYSICAL THERAPY	8,727	1,766,542	0.004940	92,289	456	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,864	1,416,886	0.002021	554,550	1,121	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	24,758	3,047,128	0.008125	834,137	6,777	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	112,398	3,310,468	0.033952	0	0	88.00
90.00	09000 CLINIC	29,774	1,098,899	0.027094	0	0	90.00
91.00	09100 EMERGENCY	49,268	3,086,532	0.015962	4,667	74	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	23,599	469,503	0.050264	0	0	92.00
200.00	Total (lines 50-199)	443,085	33,238,637		2,717,520	25,671	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141324

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

Worksheet D
Part IV
Date/Time Prepared:
8/26/2015 10:48 am

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	266,607	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	266,607	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet D Part IV Date/Time Prepared: 8/26/2015 10:48 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	1,604,559	0.000000	0.000000	38,927	50.00
53.00	05300 ANESTHESIOLOGY	0	975,509	0.273300	0.000000	14,485	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	8,604,338	0.000000	0.000000	338,142	54.00
60.00	06000 LABORATORY	0	6,544,516	0.000000	0.000000	486,655	60.00
65.00	06500 RESPIRATORY THERAPY	0	1,313,757	0.000000	0.000000	353,668	65.00
66.00	06600 PHYSICAL THERAPY	0	1,766,542	0.000000	0.000000	92,289	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,416,886	0.000000	0.000000	554,550	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3,047,128	0.000000	0.000000	834,137	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	3,310,468	0.000000	0.000000	0	88.00
90.00	09000 CLINIC	0	1,098,899	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	3,086,532	0.000000	0.000000	4,667	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	469,503	0.000000	0.000000	0	92.00
200.00	Total (lines 50-199)	0	33,238,637			2,717,520	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet D Part IV Date/Time Prepared: 8/26/2015 10:48 am
		Title XVIII	Hospital
		Cost	

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	0	0	50.00
53.00 05300 ANESTHESIOLOGY	3,959	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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0	0	88.00
90.00 09000 CLINIC	0	0	0	90.00
91.00 09100 EMERGENCY	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
200.00 Total (lines 50-199)	3,959	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet D Part V Date/Time Prepared: 8/26/2015 10:48 am
	Title XVIII	Hospital	Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.347254	0	671,863	0	0	50.00
53.00	05300 ANESTHESIOLOGY	0.295026	0	415,827	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.187238	0	2,620,842	0	0	54.00
60.00	06000 LABORATORY	0.215445	0	2,633,333	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	0.468970	0	306,504	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.351433	0	411,784	0	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130610	0	302,039	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.343941	0	861,003	0	0	73.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000 CLINIC	0.356508	0	1,098,899	0	0	90.00
91.00	09100 EMERGENCY	0.692257	0	847,542	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.785458	0	213,936	0	0	92.00
200.00	Subtotal (see instructions)		0	10,383,572	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		0	10,383,572	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet D Part V Date/Time Prepared: 8/26/2015 10:48 am
		Title XVIII	Hospital	Cost

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	233,307	0	50.00
53.00	05300 ANESTHESIOLOGY	122,680	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	490,721	0	54.00
60.00	06000 LABORATORY	567,338	0	60.00
65.00	06500 RESPIRATORY THERAPY	143,741	0	65.00
66.00	06600 PHYSICAL THERAPY	144,714	0	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	39,449	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	296,134	0	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
90.00	09000 CLINIC	391,766	0	90.00
91.00	09100 EMERGENCY	586,717	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	168,038	0	92.00
200.00	Subtotal (see instructions)	3,184,605	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	3,184,605	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 141324	Period: From 04/01/2014	Worksheet D
		Component CCN: 14Z324	To 03/31/2015	Part V
		Title XVIII	Swing Beds - SNF	Date/Time Prepared: 8/26/2015 10:48 am
				Cost

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	PPS Services (see inst.)
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.347254	0	0	0	0 50.00
53.00	05300 ANESTHESIOLOGY	0.295026	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.187238	0	0	0	0 54.00
60.00	06000 LABORATORY	0.215445	0	0	0	0 60.00
65.00	06500 RESPIRATORY THERAPY	0.468970	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.351433	0	0	0	0 66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130610	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.343941	0	0	0	0 73.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				0 88.00
90.00	09000 CLINIC	0.356508	0	0	0	0 90.00
91.00	09100 EMERGENCY	0.692257	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.785458	0	0	0	0 92.00
200.00	Subtotal (see instructions)		0	0	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	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: 141324 Component CCN: 14Z324	Period: From 04/01/2014 To 03/31/2015	Worksheet D Part V Date/Time Prepared: 8/26/2015 10:48 am
	Title XVIII	Swing Beds - SNF	Cost

Cost Center Description	Costs			Cost	
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
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
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet D-1 Date/Time Prepared: 8/26/2015 10:48 am
Cost Center Description		Title XVIII	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			3,094 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			2,577 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)			2,175 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			468 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			49 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)			1,534 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)			468 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			134.54 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			2,799,923 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)			6,592 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)			435,912 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			2,364,011 27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)			0 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			0 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000 31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00 32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			2,364,011 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)			917.35 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			1,407,215 39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			0 40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			1,407,215 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141324		Period: From 04/01/2014 To 03/31/2015		Worksheet D-1	
		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)					746,799	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,154,014	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)					429,320	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0 65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					429,320	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)					402	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					917.35	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					368,775	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 141324		Period: From 04/01/2014 To 03/31/2015		Worksheet D-1 Date/Time Prepared: 8/26/2015 10:48 am	
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	151,281	2,364,011	0.063993	368,775	23,599	90.00
91.00	Nursing School cost	0	2,364,011	0.000000	368,775	0	91.00
92.00	Allied health cost	0	2,364,011	0.000000	368,775	0	92.00
93.00	All other Medical Education	0	2,364,011	0.000000	368,775	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet D-3 Date/Time Prepared: 8/26/2015 10:48 am	
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		1,920,750		30.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.347254	38,927	13,518	50.00
53.00	05300 ANESTHESIOLOGY	0.295026	14,485	4,273	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.187238	338,142	63,313	54.00
60.00	06000 LABORATORY	0.215445	486,655	104,847	60.00
65.00	06500 RESPIRATORY THERAPY	0.468970	353,668	165,860	65.00
66.00	06600 PHYSICAL THERAPY	0.351433	92,289	32,433	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130610	554,550	72,430	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.343941	834,137	286,894	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.356508	0	0	90.00
91.00	09100 EMERGENCY	0.692257	4,667	3,231	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.785458	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		2,717,520	746,799	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		2,717,520		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet D-3	
		Component CCN: 14Z324		Date/Time Prepared: 8/26/2015 10:48 am	
Cost Center Description		Title XVIII	Swing Beds - SNF	Cost	
		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	0.347254	207	72	50.00
53.00	05300 ANESTHESIOLOGY	0.295026	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.187238	30,707	5,750	54.00
60.00	06000 LABORATORY	0.215445	52,224	11,251	60.00
65.00	06500 RESPIRATORY THERAPY	0.468970	107,776	50,544	65.00
66.00	06600 PHYSICAL THERAPY	0.351433	215,659	75,790	66.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.130610	119,796	15,647	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.343941	204,180	70,226	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000 CLINIC	0.356508	0	0	90.00
91.00	09100 EMERGENCY	0.692257	100	69	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.785458	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		730,649	229,349	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		730,649		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet E Part B Date/Time Prepared: 8/26/2015 10:48 am
		Title XVII	Hospital	Cost
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		3,184,605	1.00
2.00	Medical and other services reimbursed under OPPTS (see instructions)		0	2.00
3.00	PPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		3,184,605	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 charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		3,216,451	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)		31,430	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		1,585,378	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)		1,599,643	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		1,599,643	30.00
31.00	Primary payer payments		900	31.00
32.00	Subtotal (line 30 minus line 31)		1,598,743	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)		586,226	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		445,532	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		495,173	36.00
37.00	Subtotal (see instructions)		2,044,275	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)		2,044,275	40.00
40.01	Sequestration adjustment (see instructions)		40,886	40.01
41.00	Interim payments		1,823,184	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		180,205	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: 141324

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

Worksheet E-1
Part I
Date/Time Prepared:
8/26/2015 10:48 am

		Title XVIII		Hospital		Cost	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		2,000,556		2,574,232	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	11/18/2014	82,134	11/18/2014	215,208	3.50	
3.51		03/17/2015	56,486	03/17/2015	524,425	3.51	
3.52		06/27/2014	17,268	06/27/2014	11,415	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)		-155,888		-751,048	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,844,668		1,823,184	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		34,154		180,205	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		1,878,822		2,003,389	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: 141324
Component CCN: 14Z324

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

Worksheet E-1
Part I
Date/Time Prepared:
8/26/2015 10:48 am

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		585,861		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		585,861		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		59,752		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		645,613		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: 141324

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

Worksheet E-1
Part II
Date/Time Prepared:
8/26/2015 10:48 am

		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			722 1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			1,534 2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			0 3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			2,175 4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			36,430,789 5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			158,854 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			1 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1 8.00
9.00	Sequestration adjustment amount (see instructions)			0 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			1 10.00
INPATIENT HOSPITAL SERVICES UNDER 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)			1 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS		Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet E-2	
		Component CCN: 14Z324		Date/Time Prepared: 8/26/2015 10:48 am	
		Title XVII I	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)		433,613	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)		231,642	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		468	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)		665,255	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		665,255	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)		665,255	0	12.00
13.00	Coinurance billed to program patients (from provider records) (exclude coinurance for physician professional services)		6,466	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)		658,789	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0		16.55
17.00	Allowable bad debts (see instructions)		0	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	18.00
19.00	Total (see instructions)		658,789	0	19.00
19.01	Sequestration adjustment (see instructions)		13,176	0	19.01
20.00	Interim payments		585,861	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)		59,752	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: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet E-3 Part V Date/Time Prepared: 8/26/2015 10:48 am
		Title XVII	Hospital	Cost
				1.00
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT				
1.00	Inpatient services			2,154,014 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)			2,154,014 4.00
5.00	Primary payer payments			0 5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,175,554 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)			2,175,554 19.00
20.00	Deductibles (exclude professional component)			349,772 20.00
21.00	Excess reasonable cost (from line 16)			0 21.00
22.00	Subtotal (line 19 minus line 20 and 21)			1,825,782 22.00
23.00	Coinurance			3,344 23.00
24.00	Subtotal (line 22 minus line 23)			1,822,438 24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			124,641 25.00
26.00	Adjusted reimbursable bad debts (see instructions)			94,727 26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			94,021 27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1,917,165 28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 29.00
29.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 29.50
29.99	Recovery of Accelerated Depreciation			0 29.99
30.00	Subtotal (see instructions)			1,917,165 30.00
30.01	Sequestration adjustment (see instructions)			38,343 30.01
31.00	Interim payments			1,844,668 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)			34,154 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: 141324

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

Worksheet G

Date/Time Prepared:
8/26/2015 10:48 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	247,262	0	0	0	1.00
2.00	Temporary investments	465,896	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	7,893,722	0	0	0	4.00
5.00	Other receivable	257,674	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-5,255,761	0	0	0	6.00
7.00	Inventory	240,091	0	0	0	7.00
8.00	Prepaid expenses	327,016	0	0	0	8.00
9.00	Other current assets	17,000	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)	4,192,900	0	0	0	11.00
FIXED ASSETS						
12.00	Land	159,712	0	0	0	12.00
13.00	Land improvements	44,285	0	0	0	13.00
14.00	Accumulated depreciation	-36,068	0	0	0	14.00
15.00	Buildings	2,893,995	0	0	0	15.00
16.00	Accumulated depreciation	-1,147,111	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	4,504,744	0	0	0	23.00
24.00	Accumulated depreciation	-3,457,905	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	11,568	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	2,973,220	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	7,166,120	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	606,970	0	0	0	37.00
38.00	Salaries, wages, and fees payable	806,848	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,963,193	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	840,529	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,217,540	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	6,217,540	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	948,580				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)	948,580	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	7,166,120	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 141324

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

Worksheet G-1

Date/Time Prepared:
8/26/2015 10:48 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		145,068		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		803,512				2.00
3.00	Total (sum of line 1 and line 2)		948,580		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)		948,580		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)		948,580		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: 141324

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
8/26/2015 10:48 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	2,478,692		2,478,692	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	645,840		645,840	5.00
6.00	Swing bed - NF	67,620		67,620	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)	3,192,152		3,192,152	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)	3,192,152		3,192,152	17.00
18.00	Ancillary services	4,869,743	20,403,492	25,273,235	18.00
19.00	Outpatient services	130,316	4,524,618	4,654,934	19.00
20.00	RURAL HEALTH CLINIC	0	3,319,210	3,319,210	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	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)	8,192,211	28,247,320	36,439,531	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		15,144,357		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	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)		15,144,357		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 141324

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

Worksheet G-3

Date/Time Prepared:
8/26/2015 10:48 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	36,439,531	1.00
2.00	Less contractual allowances and discounts on patients' accounts	21,163,964	2.00
3.00	Net patient revenues (line 1 minus line 2)	15,275,567	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	15,144,357	4.00
5.00	Net income from service to patients (line 3 minus line 4)	131,210	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	726	6.00
7.00	Income from investments	13,047	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	406,425	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	27,874	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	1,575	17.00
18.00	Revenue from sale of medical records and abstracts	18,619	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	8,625	22.00
23.00	Governmental appropriations	167,025	23.00
24.00	MISCELLANEOUS INCOME	28,386	24.00
25.00	Total other income (sum of lines 6-24)	672,302	25.00
26.00	Total (line 5 plus line 25)	803,512	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)	803,512	29.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141324 Component CCN: 148506	Period: From 04/01/2014 To 03/31/2015	Worksheet M-1 Date/Time Prepared: 8/26/2015 10:48 am
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		Compensation	Other Costs	Total (col. 1 + col. 2)	Rural Health Clinic (RHC) I Reclassified	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
FACILITY HEALTH CARE STAFF COSTS							
1.00	Physician	605,294	17,640	622,934	0	622,934	1.00
2.00	Physician Assistant	341,078	0	341,078	0	341,078	2.00
3.00	Nurse Practitioner	0	0	0	27,500	27,500	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	386,680	0	386,680	0	386,680	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0	0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,333,052	17,640	1,350,692	27,500	1,378,192	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	53,793	53,793	0	53,793	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	53,793	53,793	0	53,793	14.00
15.00	Medical Supplies	0	20,530	20,530	0	20,530	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	0	0	0	0	0	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	20,530	20,530	0	20,530	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,333,052	91,963	1,425,015	27,500	1,452,515	22.00
COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
FACILITY OVERHEAD							
29.00	Facility Costs	0	35,500	35,500	0	35,500	29.00
30.00	Administrative Costs	0	56,419	56,419	6,908	63,327	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	91,919	91,919	6,908	98,827	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,333,052	183,882	1,516,934	34,408	1,551,342	32.00

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER COSTS	Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet M-1
	Component CCN: 148506		Date/Time Prepared: 8/26/2015 10:48 am
		Rural Health Clinic (RHC) I	Cost

	Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
	6.00	7.00	
FACILITY HEALTH CARE STAFF COSTS			
1.00 Physician	0	622,934	1.00
2.00 Physician Assistant	0	341,078	2.00
3.00 Nurse Practitioner	-70,807	-43,307	3.00
4.00 Visiting Nurse	0	0	4.00
5.00 Other Nurse	0	386,680	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)	-70,807	1,307,385	10.00
11.00 Physician Services Under Agreement	0	0	11.00
12.00 Physician Supervision Under Agreement	0	0	12.00
13.00 Other Costs Under Agreement	0	53,793	13.00
14.00 Subtotal (sum of lines 11 through 13)	0	53,793	14.00
15.00 Medical Supplies	0	20,530	15.00
16.00 Transportation (Health Care Staff)	0	0	16.00
17.00 Depreciation-Medical Equipment	0	0	17.00
18.00 Professional Liability Insurance	0	0	18.00
19.00 Other Health Care Costs	0	0	19.00
20.00 Allowable GME Costs	0	0	20.00
21.00 Subtotal (sum of lines 15 through 20)	0	20,530	21.00
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-70,807	1,381,708	22.00
COSTS OTHER THAN RHC/FOHC SERVICES			
23.00 Pharmacy	0	0	23.00
24.00 Dental	0	0	24.00
25.00 Optometry	0	0	25.00
26.00 All other nonreimbursable costs	0	0	26.00
27.00 Nonallowable GME costs	0	0	27.00
28.00 Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
FACILITY OVERHEAD			
29.00 Facility Costs	-5,130	30,370	29.00
30.00 Administrative Costs	0	63,327	30.00
31.00 Total Facility Overhead (sum of lines 29 and 30)	-5,130	93,697	31.00
32.00 Total facility costs (sum of lines 22, 28 and 31)	-75,937	1,475,405	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES		Provider CCN: 141324 Component CCN: 148506	Period: From 04/01/2014 To 03/31/2015	Worksheet M-2 Date/Time Prepared: 8/26/2015 10:48 am
			Rural Health Clinic (RHC) I	Cost

	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCTIVITY						
Positions						
1.00	Physician	1.69	9,699	4,200	7,098	1.00
2.00	Physician Assistant	3.83	13,482	2,100	8,043	2.00
3.00	Nurse Practitioner	0.00	0	2,100	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	5.52	23,181		15,141	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 (FOHC only)	0.00	0		0	7.01
7.02	Diabetes Self Management Training (FOHC only)	0.00	0		0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	5.52	23,181			8.00
9.00	Physician Services Under Agreements		0			9.00
					1.00	

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES			
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)		1,381,708 10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)		0 11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)		1,381,708 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)		93,697 14.00
15.00	Parent provider overhead allocated to facility (see instructions)		1,196,218 15.00
16.00	Total overhead (sum of lines 14 and 15)		1,289,915 16.00
17.00	Allowable GME overhead (see instructions)		0 17.00
18.00	Subtotal (see instructions)		1,289,915 18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)		1,289,915 19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		2,671,623 20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES		Provider CCN: 141324	Period: From 04/01/2014 To 03/31/2015	Worksheet M-3
		Component CCN: 148506		Date/Time Prepared: 8/26/2015 10:48 am
		Title XVIII	Rural Health Clinic (RHC) I	Cost
				1.00
DETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		2,671,623	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		103,633	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,567,990	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		23,181	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)		23,181	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		110.78	7.00
		Calculation of Limit (1)		
		Prior to January 1	On or After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	0.00	0.00	8.00
9.00	Rate for Program covered visits (see instructions)	110.78	110.78	9.00
CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from contractor records)	0	7,065	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	782,661	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) *		782,661	16.00
16.01	Total program charges (see instructions)(from contractor's records)		869,200	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		342	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		308	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.)		550,515	16.04
16.05	Total program cost (see instructions)		550,823	16.05
17.00	Primary payer amounts		623	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		94,209	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		154,930	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		550,200	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		53,605	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		603,805	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		603,805	26.00
26.01	Sequestration adjustment (see instructions)		12,076	26.01
27.00	Interim payments		617,671	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)		-25,942	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-11, chapter 1, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 141324 Component CCN: 148506	Period: From 04/01/2014 To 03/31/2015	Worksheet M-4 Date/Time Prepared: 8/26/2015 10:48 am		
		Title XVIII	Rural Health Clinic (RHC) I	Cost		
				Pneumococcal	Influenza	
				1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)			1,307,385	1,307,385	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time			0.001524	0.025149	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)			1,992	32,879	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)			5,081	13,645	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)			7,073	46,524	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)			1,381,708	1,381,708	6.00
7.00	Total overhead (from Wkst. M-2, line 16)			1,289,915	1,289,915	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)			0.005119	0.033671	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)			6,603	43,433	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)			13,676	89,957	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)			70	1,155	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)			195.37	77.88	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries			34	603	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)			6,643	46,962	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)				103,633	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)				53,605	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141324 Component CCN: 148506	Period: From 04/01/2014 To 03/31/2015	Worksheet M-5 Date/Time Prepared: 8/26/2015 10:48 am
		Rural Health Clinic (RHC) I	Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		688,233	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
Program to Provider				
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3.50		11/18/2014	70,562	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)		-70,562	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		617,671	4.00
TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program				
5.50			0	5.50
5.51			0	5.51
5.52			0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER		0	6.01
6.02	SETTLEMENT TO PROGRAM		25,942	6.02
7.00	Total Medicare program liability (see instructions)		591,729	7.00
		Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00 2.00	
8.00	Name of Contractor			8.00