This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Provider CCN: 141327

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

Worksheet S
Parts I-III
Date/Time Prepared:
5/24/2016 3:33 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 5/24/2016 Time: 3:33 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by WABASH GENERAL HOSPITAL (141327) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	167,170	93,512	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	1,651	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		1,785		0	10.00
200.00	Total	0	168,821	95,297	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2016 10:42 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1418 COLLEGE DRIVE	PO Box:			1.00
2.00	City: MT. CARMEL	State: IL	Zip Code: 62863-	County: WABASH	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	WABASH GENERAL HOSPITAL	141327	99914	1	06/01/2003	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	WABASH GENERAL HOSPITAL SWING BEDS	14Z327	14999		06/01/2003	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	WABASH GENERAL RHC	148501	14999		04/01/2009	N	O	N	15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	01/01/2015	12/31/2015	20.00
21.00	Type of Control (see instructions)	2		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N	23.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2016 10:42 am

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2016 10:42 am

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2016 10:42 am

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

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

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	N			70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I | Date/Time Prepared: 5/24/2016 10:42 am

		V	XIX	
		1.00	2.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a critical access hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Y		108.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part I Date/Time Prepared: 5/24/2016 10:42 am

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

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

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

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

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

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

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

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

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

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2015	12/31/2015	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141327	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Prepared: 5/24/2016 10:42 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2016 10:42 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	C	06/01/2016	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	04/13/2016	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II Date/Time Prepared: 5/24/2016 10:42 am

		Description	Part A Y/N	Part A Date	Part B Y/N	
		0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RICH	FERRIELL	41.00
42.00	Enter the employer/company name of the cost report preparer.	ALLIANT MANAGEMENT SERVICES		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	5029923832	RFERRIELL@ALLIANTMANAGEMENT.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-2 Part II | Date/Time Prepared: 5/24/2016 10:42 am

		Part B Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	04/13/2016			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)				17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		REIMBURSEMENT MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I Date/Time Prepared: 5/24/2016 10:42 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	21	7,665	60,069.00	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)		21	7,665	60,069.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	4	1,460	343.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	60,412.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2016 10:42 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)	1,710	168	2,384			1.00
2.00	HMO and other (see instructions)	13	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	232	0	232			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		63	63			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,942	231	2,679			7.00
8.00	INTENSIVE CARE UNIT	47	38	85			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1,989	269	2,764	0.00	219.83	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	326	0	5,304	0.00	2.21	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	222.04	27.00
28.00	Observation Bed Days		0	269			28.00
29.00	Ambulance Trips	814					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: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part I | Date/Time Prepared: 5/24/2016 10:42 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	473	58	712	1.00
2.00	HMO and other (see instructions)			3	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	473	58	712	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-3 Part IV Date/Time Prepared: 5/24/2016 10:42 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	330,227	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	2,286,220	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	183,490	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	922,301	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	8,995	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	3,731,233	24.00
	Part B - Other than Core Related Cost		
25.00	EMPLOYEE BENEFITS	-1,786	25.00

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

Provider CCN: 141327 Component CCN: 148501 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-8 Date/Time Prepared: 5/24/2016 10:42 am

		Rural Health Clinic (RHC) I	Cost
		1.00	
	Clinic Address and Identification		
1.00	Street	1418 COLLEGE DRIVE	1.00
		City / State / ZIP Code	
		1.00 / 2.00 / 3.00	
2.00	City, State, ZIP Code, County	MT.CARMEL IL 62863	2.00
			1.00
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban		0 3.00
		Grant Award / Date	
		1.00 / 2.00	
	Source of Federal Funds		
4.00	Community Health Center (Section 330(d), PHS Act)	0	4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)	0	5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)	0	6.00
7.00	Appalachian Regional Commission	0	7.00
8.00	Look-Alikes	0	8.00
9.00	OTHER (SPECIFY)	0	9.00
9.01		0	9.01
9.02		0	9.02
9.03		0	9.03
9.04		0	9.04
9.05		0	9.05
9.06		0	9.06
9.07		0	9.07
9.08		0	9.08
9.09		0	9.09
9.10		0	9.10
		1.00	2.00
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)	N	0 10.00

		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic	10:00	22:00	15:00	21:00	15:00	11.00

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

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

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

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

Provider CCN: 141327
Component CCN: 148501

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

Worksheet S-8

Date/Time Prepared:
5/24/2016 10:42 am

Rural Health Clinic (RHC) I

Cost

			County				
			4.00				
2.00	City, State, ZIP Code, County		WABASH				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	21:00	18:00	21:00	18:00	21:00	11.00
		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	15:00	21:00	10:00	22:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet S-10 | Date/Time Prepared: 5/24/2016 10:42 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)	0.390613	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	3,257,287	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	N	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	0	5.00
6.00	Medicaid charges	13,373,675	6.00
7.00	Medicaid cost (line 1 times line 6)	5,223,931	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)	1,966,644	8.00
	State Children's Health Insurance Program (SCHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone SCHIP	0	9.00
10.00	Stand-alone SCHIP charges	0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Uncompensated care (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	1,966,644	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	67,694	7,611	75,305	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	26,442	2,973	29,415	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	26,442	2,973	29,415	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	3,527,693	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	223,432	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	3,304,261	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,290,687	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1,320,102	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	3,286,746	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/24/2016 10:42 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	NEW CAP REL COSTS-BLDG & FIXT		678,845	678,845	0	678,845	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		694,169	694,169	760,436	1,454,605	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	142,987	4,128,109	4,271,096	0	4,271,096	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	1,014,247	4,391,710	5,405,957	41,530	5,447,487	5.00
7.00	00700	OPERATION OF PLANT	191,894	943,414	1,135,308	29,296	1,164,604	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	228,080	52,916	280,996	125,161	406,157	9.00
10.00	01000	DIETARY	361,771	220,529	582,300	-393,999	188,301	10.00
11.00	01100	CAFETERIA	0	0	0	392,887	392,887	11.00
13.00	01300	NURSING ADMINISTRATION	217,753	25,161	242,914	0	242,914	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	362,210	59,608	421,818	0	421,818	16.00
17.00	01700	SOCIAL SERVICE	140,756	6,776	147,532	0	147,532	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	733,582	59,894	793,476	-6,715	786,761	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,305,579	470,069	1,775,648	-55,297	1,720,351	30.00
31.00	03100	INTENSIVE CARE UNIT	236,827	1,487	238,314	-1,375	236,939	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	708,204	343,576	1,051,780	-82,810	968,970	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	652,235	864,459	1,516,694	-140,682	1,376,012	54.00
60.00	06000	LABORATORY	711,752	683,019	1,394,771	-101,406	1,293,365	60.00
65.00	06500	RESPIRATORY THERAPY	494,451	178,039	672,490	-29,264	643,226	65.00
66.00	06600	PHYSICAL THERAPY	689,220	64,118	753,338	-1,973	751,365	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	117,872	3,884,105	4,001,977	-2,817,362	1,184,615	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	2,996,546	2,996,546	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	366,699	1,639,236	2,005,935	4,506	2,010,441	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	193,779	30,235	224,014	-1,733	222,281	88.00
90.00	09000	CLINIC	198,730	150,380	349,110	-367	348,743	90.00
90.01	09001	ORTHOPAEDIC CLINIC	2,672,553	323,930	2,996,483	-49,697	2,946,786	90.01
90.02	09002	SURGICAL CLINIC	530,426	75,342	605,768	-41,360	564,408	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	851,871	1,474,324	2,326,195	-120,353	2,205,842	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	591,258	131,864	723,122	-30,511	692,611	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		292,887	292,887	-292,887	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,714,736	21,868,201	35,582,937	182,571	35,765,508	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	477,664	660,676	1,138,340	-182,571	955,769	192.00
200.00		TOTAL (SUM OF LINES 118-199)	14,192,400	22,528,877	36,721,277	0	36,721,277	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A | Date/Time Prepared: 5/24/2016 10:42 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	0	678,845		1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	-205,441	1,249,164		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-861,473	3,409,623		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-482,825	4,964,662		5.00
7.00	00700	OPERATION OF PLANT	0	1,164,604		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0		8.00
9.00	00900	HOUSEKEEPING	0	406,157		9.00
10.00	01000	DIETARY	-5,344	182,957		10.00
11.00	01100	CAFETERIA	-76,838	316,049		11.00
13.00	01300	NURSING ADMINISTRATION	0	242,914		13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-25,883	395,935		16.00
17.00	01700	SOCIAL SERVICE	0	147,532		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-733,582	53,179		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-361,600	1,358,751		30.00
31.00	03100	INTENSIVE CARE UNIT	0	236,939		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	968,970		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,521	1,379,533		54.00
60.00	06000	LABORATORY	-49,228	1,244,137		60.00
65.00	06500	RESPIRATORY THERAPY	-59,271	583,955		65.00
66.00	06600	PHYSICAL THERAPY	0	751,365		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	-1,701	1,182,914		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	2,996,546		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-300	2,010,141		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	222,281		88.00
90.00	09000	CLINIC	-125,238	223,505		90.00
90.01	09001	ORTHOPAEDIC CLINIC	-1,802,653	1,144,133		90.01
90.02	09002	SURGICAL CLINIC	-324,364	240,044		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	-899,505	1,306,337		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0	692,611		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-6,011,725	29,753,783		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	955,769		192.00
200.00		TOTAL (SUM OF LINES 118-199)	-6,011,725	30,709,552		200.00

RECLASSIFICATIONS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/24/2016 10:42 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - RENT				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	379,631	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
	TOTALS		0	379,631	
	B - CAFETERIA				
1.00	CAFETERIA	11.00	244,093	148,794	1.00
	TOTALS		244,093	148,794	
	C - IV SOLUTIONS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	6,551	1.00
	TOTALS		0	6,551	
	D - MATERIALS MANAGEMENT				
1.00	ADMINISTRATIVE & GENERAL	5.00	58,488	0	1.00
	TOTALS		58,488	0	
	E - INTEREST				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	292,887	1.00
	TOTALS		0	292,887	
	F - OXYGEN				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	7,808	1.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		0	7,808	
	G - MED SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	236,415	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
	TOTALS		0	236,415	
	H - UTILITIES				
1.00	OPERATION OF PLANT	7.00	0	29,296	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	29,296	
	I - IMPLANTS				
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	2,996,546	1.00
	TOTALS		0	2,996,546	
	J - LINEN				
1.00	HOUSEKEEPING	9.00	0	125,161	1.00
	TOTALS		0	125,161	
	L - INSURANCE				
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	87,918	1.00
	TOTALS		0	87,918	
	M - MALPRACTICE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	73,408	1.00
	TOTALS		0	73,408	
500.00	Grand Total: Increases		302,581	4,384,415	500.00

RECLASSIFICATIONS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-6 | Date/Time Prepared: 5/24/2016 10:42 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - RENT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,448	9		1.00
2.00	DIETARY	10.00	0	1,112	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	956	0		3.00
4.00	OPERATING ROOM	50.00	0	37,158	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	131,031	0		5.00
6.00	LABORATORY	60.00	0	68,427	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	7,548	0		7.00
9.00	ORTHOPAEDIC CLINIC	90.01	0	37,644	0		9.00
10.00	SURGICAL CLINIC	90.02	0	33,792	0		10.00
11.00	AMBULANCE SERVICES	95.00	0	23,833	0		11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	35,682	0		12.00
	TOTALS		0	379,631			
	B - CAFETERIA						
1.00	DIETARY	10.00	244,093	148,794	0		1.00
	TOTALS		244,093	148,794			
	C - IV SOLUTIONS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,551	0		1.00
	TOTALS		0	6,551			
	D - MATERIALS MANAGEMENT						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	58,488	0	0		1.00
	TOTALS		58,488	0			
	E - INTEREST						
1.00	INTEREST EXPENSE	113.00	0	292,887	9		1.00
	TOTALS		0	292,887			
	F - OXYGEN						
1.00		0.00	0	0	0		1.00
3.00	RESPIRATORY THERAPY	65.00	0	6,990	0		3.00
4.00	AMBULANCE SERVICES	95.00	0	818	0		4.00
	TOTALS		0	7,808			
	G - MED SUPPLIES						
1.00	NONPHYSICIAN ANESTHETISTS	19.00	0	6,715	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	54,341	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	1,375	0		3.00
4.00	OPERATING ROOM	50.00	0	45,652	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	9,651	0		5.00
6.00	LABORATORY	60.00	0	32,979	0		6.00
7.00	RESPIRATORY THERAPY	65.00	0	14,726	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	1,973	0		8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,045	0		9.00
10.00	CLINIC	90.00	0	367	0		10.00
11.00	ORTHOPAEDIC CLINIC	90.01	0	12,053	0		11.00
12.00	EMERGENCY	91.00	0	46,945	0		12.00
13.00	RURAL HEALTH CLINIC	88.00	0	1,733	0		13.00
14.00	AMBULANCE SERVICES	95.00	0	5,860	0		14.00
	TOTALS		0	236,415			
	H - UTILITIES						
1.00	SURGICAL CLINIC	90.02	0	7,568	0		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	21,728	0		2.00
	TOTALS		0	29,296			
	I - IMPLANTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	2,996,546	0		1.00
	TOTALS		0	2,996,546			
	J - LINEN						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	125,161	0		1.00
	TOTALS		0	125,161			
	L - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	87,918	9		1.00
	TOTALS		0	87,918			
	M - MALPRACTICE						
1.00	EMERGENCY	91.00	0	73,408	0		1.00
	TOTALS		0	73,408			
500.00	Grand Total: Decreases		302,581	4,384,415			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part I | Date/Time Prepared: 5/24/2016 10:42 am

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	416,867	0	0	0	0	1.00
2.00	Land Improvements	1,553,816	369,629	0	369,629	0	2.00
3.00	Buildings and Fixtures	18,908,321	990,288	0	990,288	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	3,648,475	513,551	0	513,551	0	5.00
6.00	Movable Equipment	11,203,895	1,157,854	0	1,157,854	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35,731,374	3,031,322	0	3,031,322	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	35,731,374	3,031,322	0	3,031,322	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	416,867	0	1.00
2.00	Land Improvements	1,923,445	0	2.00
3.00	Buildings and Fixtures	19,898,609	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	4,162,026	0	5.00
6.00	Movable Equipment	12,361,749	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	38,762,696	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	38,762,696	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part II | Date/Time Prepared: 5/24/2016 10:42 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	NEW CAP REL COSTS-BLDG & FIXT	678,845	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	694,169	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,373,014	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL			
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)		
		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	678,845		1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	694,169		2.00
3.00	Total (sum of lines 1-2)	0	1,373,014		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-7 Part III Date/Time Prepared: 5/24/2016 10:42 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	NEW CAP REL COSTS-BLDG & FIXT	1	0	1	1.000000	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	1	0	1	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	678,845	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,249,164	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1,928,009	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 cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	0	678,845	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,249,164	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	1,928,009	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/24/2016 10:42 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-44,797	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	2.00
3.00	Investment income - other (chapter 2)	B	-44,545	ADMINISTRATIVE & GENERAL	5.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-3,620,563			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	2,225			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-76,838	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	B	-1,701	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	16.00
17.00	Sale of drugs to other than patients	B	-300	DRUGS CHARGED TO PATIENTS	73.00	0	17.00
18.00	Sale of medical records and abstracts	B	-25,883	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	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
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-176,633	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8 | Date/Time Prepared: 5/24/2016 10:42 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	DIETARY	B	-5,344	DIETARY	10.00	0	33.00
35.00	MISCELLANEOUS	B	-10,992	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	PHYSICIAN RECRUITMENT	A	-417,317	ADMINISTRATIVE & GENERAL	5.00	0	36.00
37.00	PUBLIC RELATIONS	A	-211,492	EMPLOYEE BENEFITS	4.00	0	37.00
39.00	CRNA SALARY	A	-733,582	NONPHYSICIAN ANESTHETISTS	19.00	0	39.00
40.00	CRNA EMP BEN	A	-192,769	EMPLOYEE BENEFITS	4.00	0	40.00
42.00	EMPLOYEE DISCOUNT	A	101,721	EMPLOYEE BENEFITS	4.00	0	42.00
43.00	ORTHO EMP BEN	A	-473,697	EMPLOYEE BENEFITS	4.00	0	43.00
44.00	SURGEONS EMP BEN	A	-85,236	EMPLOYEE BENEFITS	4.00	0	44.00
45.00	BOND ISSUANCE	A	15,989	NEW CAP REL COSTS-MVBLE EQUIP	2.00	9	45.00
46.00	IHA DUES	A	-9,971	ADMINISTRATIVE & GENERAL	5.00	0	46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-6,011,725				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141327	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 5/24/2016 10:42 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	54.00	RADIOLOGY-DIAGNOSTIC	DSS MRI	220,573	218,348	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	0		0	220,573	218,348	5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

				Related Organization(s) and/or Home Office		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	A	DSS MRI	100.00		0.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 141327	Period: From 01/01/2015 To 12/31/2015	Worksheet A-8-1 Date/Time Prepared: 5/24/2016 10:42 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	2,225	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	2,225			5.00

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate.Positive amounts increase cost and negative amounts decrease cost.For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

	Related Organization(s) and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:		

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

(1) Use the following symbols to indicate interrelationship to related organizations:

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
B. Corporation, partnership, or other organization has financial interest in provider.
C. Provider has financial interest in corporation, partnership, or other organization.
D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet A-8-2 | Date/Time Prepared: 5/24/2016 10:42 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	361,600	361,600	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	-1,296	-1,296	0	0	0	2.00
3.00	60.00	LABORATORY	49,228	49,228	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	59,271	59,271	0	0	0	4.00
5.00	90.00	CLINIC	125,238	125,238	0	0	0	5.00
6.00	90.01	ORTHOPAEDIC CLINIC	1,802,653	1,802,653	0	0	0	6.00
7.00	90.02	SURGICAL CLINIC	324,364	324,364	0	0	0	7.00
8.00	91.00	EMERGENCY	1,298,302	899,505	398,797	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			4,019,360	3,620,563	398,797		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	4.00
5.00	90.00	CLINIC	0	0	0	0	0	5.00
6.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	0	0	6.00
7.00	90.02	SURGICAL CLINIC	0	0	0	0	0	7.00
8.00	91.00	EMERGENCY	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	361,600		1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	-1,296		2.00
3.00	60.00	LABORATORY	0	0	0	49,228		3.00
4.00	65.00	RESPIRATORY THERAPY	0	0	0	59,271		4.00
5.00	90.00	CLINIC	0	0	0	125,238		5.00
6.00	90.01	ORTHOPAEDIC CLINIC	0	0	0	1,802,653		6.00
7.00	90.02	SURGICAL CLINIC	0	0	0	324,364		7.00
8.00	91.00	EMERGENCY	0	0	0	899,505		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	3,620,563		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/24/2016 10:42 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	678,845	678,845				1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	1,249,164		1,249,164			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	3,409,623	3,543	6,520	3,419,686		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,964,662	49,550	91,179	327,864	5,433,255	5.00
7.00	00700	OPERATION OF PLANT	1,164,604	28,620	52,665	58,649	1,304,538	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	406,157	2,814	5,178	69,709	483,858	9.00
10.00	01000	DIETARY	182,957	21,306	39,205	35,966	279,434	10.00
11.00	01100	CAFETERIA	316,049	8,841	16,269	74,603	415,762	11.00
13.00	01300	NURSING ADMINISTRATION	242,914	1,663	3,061	66,553	314,191	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	395,935	9,719	17,884	110,704	534,242	16.00
17.00	01700	SOCIAL SERVICE	147,532	2,028	3,732	43,020	196,312	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	53,179	0	0	0	53,179	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,358,751	89,917	165,459	399,033	2,013,160	30.00
31.00	03100	INTENSIVE CARE UNIT	236,939	9,081	16,709	72,382	335,111	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	968,970	105,060	193,324	216,451	1,483,805	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,379,533	30,056	55,307	199,345	1,664,241	54.00
60.00	06000	LABORATORY	1,244,137	21,431	39,436	217,536	1,522,540	60.00
65.00	06500	RESPIRATORY THERAPY	583,955	9,411	17,317	151,121	761,804	65.00
66.00	06600	PHYSICAL THERAPY	751,365	78,752	144,913	210,649	1,185,679	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,182,914	12,840	23,628	18,150	1,237,532	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	2,996,546	0	0	0	2,996,546	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,010,141	6,323	11,636	112,076	2,140,176	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	222,281	10,641	19,582	59,225	311,729	88.00
90.00	09000	CLINIC	223,505	23,140	42,581	60,739	349,965	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1,144,133	82,033	150,951	265,871	1,642,988	90.01
90.02	09002	SURGICAL CLINIC	240,044	0	0	62,980	303,024	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	1,306,337	25,476	46,879	260,361	1,639,053	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	692,611	40,652	74,805	180,709	988,777	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,753,783	672,897	1,238,220	3,273,696	29,590,901	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,507	4,612	0	7,119	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	955,769	3,441	6,332	145,990	1,111,532	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	30,709,552	678,845	1,249,164	3,419,686	30,709,552	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/24/2016 10:42 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5,433,255					5.00
7.00	00700	OPERATION OF PLANT	280,417	1,584,955				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	104,008	7,470	0	595,336		9.00
10.00	01000	DIETARY	60,066	56,552	0	9,559	405,611	10.00
11.00	01100	CAFETERIA	89,370	23,467	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	67,537	4,415	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	114,838	25,796	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	42,198	5,383	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	11,431	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	432,739	238,666	0	258,284	393,137	30.00
31.00	03100	INTENSIVE CARE UNIT	72,034	24,102	0	0	12,474	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	318,951	278,856	0	96,683	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	357,737	79,777	0	48,886	0	54.00
60.00	06000	LABORATORY	327,278	56,884	0	2,647	0	60.00
65.00	06500	RESPIRATORY THERAPY	163,754	24,979	0	12,413	0	65.00
66.00	06600	PHYSICAL THERAPY	254,868	209,029	0	50,062	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	266,014	34,082	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	644,108	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	460,042	16,784	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	67,008	28,246	0	0	0	88.00
90.00	09000	CLINIC	75,227	61,420	0	2,588	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	353,168	217,739	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	65,137	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	352,323	67,620	0	113,861	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	212,543	107,902	0	353	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,192,796	1,569,169	0	595,336	405,611	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,530	6,653	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	238,929	9,133	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	5,433,255	1,584,955	0	595,336	405,611	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/24/2016 10:42 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	528,599					11.00
13.00	01300	NURSING ADMINISTRATION	6,136	392,279				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	28,635	0	703,511			16.00
17.00	01700	SOCIAL SERVICE	6,839	0	0	250,732		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	8,980	0	0	0	73,590	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	80,856	178,661	85,286	243,021	0	30.00
31.00	03100	INTENSIVE CARE UNIT	11,026	24,363	0	7,711	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	39,789	87,919	90,054	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	73,590	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	32,918	0	182,587	0	0	54.00
60.00	06000	LABORATORY	38,446	0	76,566	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	25,375	0	20,545	0	0	65.00
66.00	06600	PHYSICAL THERAPY	30,872	0	8,038	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,867	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	10,738	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	7,063	0	43,869	0	0	88.00
90.00	09000	CLINIC	10,770	0	75,858	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	83,861	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	14,733	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	45,861	101,336	112,261	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	41,834	0	8,447	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	528,599	392,279	703,511	250,732	73,590	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	528,599	392,279	703,511	250,732	73,590	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part I | Date/Time Prepared: 5/24/2016 10:42 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	3,923,810	0	3,923,810		30.00
31.00	03100	INTENSIVE CARE UNIT	486,821	0	486,821		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	2,396,057	0	2,396,057		50.00
53.00	05300	ANESTHESIOLOGY	73,590	0	73,590		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,366,146	0	2,366,146		54.00
60.00	06000	LABORATORY	2,024,361	0	2,024,361		60.00
65.00	06500	RESPIRATORY THERAPY	1,008,870	0	1,008,870		65.00
66.00	06600	PHYSICAL THERAPY	1,738,548	0	1,738,548		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,541,495	0	1,541,495		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,640,654	0	3,640,654		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,627,740	0	2,627,740		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	457,915	0	457,915		88.00
90.00	09000	CLINIC	575,828	0	575,828		90.00
90.01	09001	ORTHOPAEDIC CLINIC	2,297,756	0	2,297,756		90.01
90.02	09002	SURGICAL CLINIC	382,894	0	382,894		90.02
90.03	09003	OP CLINIC	0	0	0		90.03
91.00	09100	EMERGENCY	2,432,315	0	2,432,315		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	1,359,856	0	1,359,856		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	29,334,656	0	29,334,656		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,302	0	15,302		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,359,594	0	1,359,594		192.00
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	30,709,552	0	30,709,552		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/24/2016 10:42 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	CAPITAL RELATED COSTS NEW MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	3,543	6,520	10,063	10,063	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	49,550	91,179	140,729	964	5.00
7.00	00700	OPERATION OF PLANT	0	28,620	52,665	81,285	173	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	2,814	5,178	7,992	205	9.00
10.00	01000	DIETARY	0	21,306	39,205	60,511	106	10.00
11.00	01100	CAFETERIA	0	8,841	16,269	25,110	219	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,663	3,061	4,724	196	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	9,719	17,884	27,603	326	16.00
17.00	01700	SOCIAL SERVICE	0	2,028	3,732	5,760	127	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	89,917	165,459	255,376	1,176	30.00
31.00	03100	INTENSIVE CARE UNIT	0	9,081	16,709	25,790	213	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	105,060	193,324	298,384	637	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,056	55,307	85,363	586	54.00
60.00	06000	LABORATORY	0	21,431	39,436	60,867	640	60.00
65.00	06500	RESPIRATORY THERAPY	0	9,411	17,317	26,728	445	65.00
66.00	06600	PHYSICAL THERAPY	0	78,752	144,913	223,665	620	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12,840	23,628	36,468	53	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,323	11,636	17,959	330	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	10,641	19,582	30,223	174	88.00
90.00	09000	CLINIC	0	23,140	42,581	65,721	179	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	82,033	150,951	232,984	782	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	185	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	25,476	46,879	72,355	766	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	40,652	74,805	115,457	532	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	672,897	1,238,220	1,911,117	9,634	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,507	4,612	7,119	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,441	6,332	9,773	429	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	678,845	1,249,164	1,928,009	10,063	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/24/2016 10:42 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	141,693					5.00
7.00	00700	OPERATION OF PLANT	7,313	88,771				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0			8.00
9.00	00900	HOUSEKEEPING	2,713	418	0	11,328		9.00
10.00	01000	DIETARY	1,567	3,167	0	182	65,533	10.00
11.00	01100	CAFETERIA	2,331	1,314	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,761	247	0	0	0	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,995	1,445	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,101	301	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	298	0	0	0	0	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	11,286	13,367	0	4,914	63,518	30.00
31.00	03100	INTENSIVE CARE UNIT	1,879	1,350	0	0	2,015	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,318	15,621	0	1,840	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,330	4,468	0	930	0	54.00
60.00	06000	LABORATORY	8,535	3,186	0	50	0	60.00
65.00	06500	RESPIRATORY THERAPY	4,271	1,399	0	236	0	65.00
66.00	06600	PHYSICAL THERAPY	6,647	11,707	0	953	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,938	1,909	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,789	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,998	940	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,748	1,582	0	0	0	88.00
90.00	09000	CLINIC	1,962	3,440	0	49	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	9,211	12,195	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	1,699	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	9,189	3,787	0	2,167	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,543	6,043	0	7	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	135,422	87,886	0	11,328	65,533	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40	373	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,231	512	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	141,693	88,771	0	11,328	65,533	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II Date/Time Prepared: 5/24/2016 10:42 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	
			11.00	13.00	16.00	17.00	19.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	28,974					11.00
13.00	01300	NURSING ADMINISTRATION	336	7,264				13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,570	0	33,939			16.00
17.00	01700	SOCIAL SERVICE	375	0	0	7,664		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	492	0	0	0	790	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,432	3,309	4,114	7,428		30.00
31.00	03100	INTENSIVE CARE UNIT	604	451	0	236		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,181	1,628	4,344	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,804	0	8,809	0		54.00
60.00	06000	LABORATORY	2,107	0	3,694	0		60.00
65.00	06500	RESPIRATORY THERAPY	1,391	0	991	0		65.00
66.00	06600	PHYSICAL THERAPY	1,692	0	388	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	212	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	589	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	387	0	2,116	0		88.00
90.00	09000	CLINIC	590	0	3,660	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	4,597	0	0	0		90.01
90.02	09002	SURGICAL CLINIC	808	0	0	0		90.02
90.03	09003	OP CLINIC	0	0	0	0		90.03
91.00	09100	EMERGENCY	2,514	1,876	5,416	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,293	0	407	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	28,974	7,264	33,939	7,664	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments					790	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	28,974	7,264	33,939	7,664	790	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B Part II | Date/Time Prepared: 5/24/2016 10:42 am

		Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
		GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	368,920	0	368,920		30.00
31.00	03100	INTENSIVE CARE UNIT	32,538	0	32,538		31.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	332,953	0	332,953		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111,290	0	111,290		54.00
60.00	06000	LABORATORY	79,079	0	79,079		60.00
65.00	06500	RESPIRATORY THERAPY	35,461	0	35,461		65.00
66.00	06600	PHYSICAL THERAPY	245,672	0	245,672		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,580	0	45,580		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,789	0	16,789		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,816	0	31,816		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	36,230	0	36,230		88.00
90.00	09000	CLINIC	75,601	0	75,601		90.00
90.01	09001	ORTHOPAEDIC CLINIC	259,769	0	259,769		90.01
90.02	09002	SURGICAL CLINIC	2,692	0	2,692		90.02
90.03	09003	OP CLINIC	0	0	0		90.03
91.00	09100	EMERGENCY	98,070	0	98,070		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	130,282	0	130,282		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,902,742	0	1,902,742		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	7,532	0	7,532		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	16,945	0	16,945		192.00
200.00		Cross Foot Adjustments	790	0	790		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118-201)	1,928,009	0	1,928,009		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/24/2016 10:42 am

		Cost Center Description	CAPITAL RELATED COSTS					
			NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	59,582					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		59,582				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	311	311	11,188,816			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,349	4,349	1,072,735	-5,433,255	25,276,297	5.00
7.00	00700	OPERATION OF PLANT	2,512	2,512	191,894	0	1,304,538	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	247	247	228,080	0	483,858	9.00
10.00	01000	DIETARY	1,870	1,870	117,678	0	279,434	10.00
11.00	01100	CAFETERIA	776	776	244,093	0	415,762	11.00
13.00	01300	NURSING ADMINISTRATION	146	146	217,753	0	314,191	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	853	853	362,210	0	534,242	16.00
17.00	01700	SOCIAL SERVICE	178	178	140,756	0	196,312	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	53,179	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,892	7,892	1,305,579	0	2,013,160	30.00
31.00	03100	INTENSIVE CARE UNIT	797	797	236,827	0	335,111	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,221	9,221	708,204	0	1,483,805	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,638	2,638	652,235	0	1,664,241	54.00
60.00	06000	LABORATORY	1,881	1,881	711,752	0	1,522,540	60.00
65.00	06500	RESPIRATORY THERAPY	826	826	494,451	0	761,804	65.00
66.00	06600	PHYSICAL THERAPY	6,912	6,912	689,220	0	1,185,679	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,127	1,127	59,384	0	1,237,532	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	2,996,546	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	555	555	366,699	0	2,140,176	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	934	934	193,779	0	311,729	88.00
90.00	09000	CLINIC	2,031	2,031	198,730	0	349,965	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,200	7,200	869,901	0	1,642,988	90.01
90.02	09002	SURGICAL CLINIC	0	0	206,063	0	303,024	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,236	2,236	851,871	0	1,639,053	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,568	3,568	591,258	0	988,777	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	59,060	59,060	10,711,152	-5,433,255	24,157,646	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	220	220	0	0	7,119	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	302	302	477,664	0	1,111,532	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	678,845	1,249,164	3,419,686		5,433,255	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	11.393458	20.965459	0.305634		0.214955	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			10,063		141,693	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000899		0.005606	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/24/2016 10:42 am

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (POUNDS)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	52,410					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	20,240				8.00
9.00	00900	HOUSEKEEPING	247	0	20,240			9.00
10.00	01000	DIETARY	1,870	325	325	8,292		10.00
11.00	01100	CAFETERIA	776	0	0	0	16,540	11.00
13.00	01300	NURSING ADMINISTRATION	146	0	0	0	192	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	853	0	0	0	896	16.00
17.00	01700	SOCIAL SERVICE	178	0	0	0	214	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	281	19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,892	8,781	8,781	8,037	2,530	30.00
31.00	03100	INTENSIVE CARE UNIT	797	0	0	255	345	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,221	3,287	3,287	0	1,245	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,638	1,662	1,662	0	1,030	54.00
60.00	06000	LABORATORY	1,881	90	90	0	1,203	60.00
65.00	06500	RESPIRATORY THERAPY	826	422	422	0	794	65.00
66.00	06600	PHYSICAL THERAPY	6,912	1,702	1,702	0	966	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,127	0	0	0	121	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	555	0	0	0	336	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	934	0	0	0	221	88.00
90.00	09000	CLINIC	2,031	88	88	0	337	90.00
90.01	09001	ORTHOPAEDIC CLINIC	7,200	0	0	0	2,624	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	461	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,236	3,871	3,871	0	1,435	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	3,568	12	12	0	1,309	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	51,888	20,240	20,240	8,292	16,540	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	220	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	302	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,584,955	0	595,336	405,611	528,599	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.241462	0.000000	29.413834	48.915943	31.958827	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	88,771	0	11,328	65,533	28,974	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.693780	0.000000	0.559684	7.903160	1.751753	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet B-1 | Date/Time Prepared: 5/24/2016 10:42 am

		Cost Center Description	NURSING ADMINISTRATION (NURSE FTE'S)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)		
			13.00	16.00	17.00	19.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	5,555					13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	129,095				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,764			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	100		19.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,530	15,650	2,679	0		30.00
31.00	03100	INTENSIVE CARE UNIT	345	0	85	0		31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,245	16,525	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	100		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,505	0	0		54.00
60.00	06000	LABORATORY	0	14,050	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	3,770	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	1,475	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 PATIENT	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	8,050	0	0		88.00
90.00	09000	CLINIC	0	13,920	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0		90.02
90.03	09003	OP CLINIC	0	0	0	0		90.03
91.00	09100	EMERGENCY	1,435	20,600	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,550	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	5,555	129,095	2,764	100		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	392,279	703,511	250,732	73,590		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	70.617282	5.449560	90.713459	735.900000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,264	33,939	7,664	790		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.307651	0.262899	2.772793	7.900000		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 10:42 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,923,810		3,923,810	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	486,821		486,821	0	0	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,396,057		2,396,057	0	0	50.00
53.00	05300	ANESTHESIOLOGY	73,590		73,590	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,366,146		2,366,146	0	0	54.00
60.00	06000	LABORATORY	2,024,361		2,024,361	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	1,008,870	0	1,008,870	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,738,548	0	1,738,548	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,541,495		1,541,495	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,640,654		3,640,654	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,627,740		2,627,740	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	457,915		457,915	0	0	88.00
90.00	09000	CLINIC	575,828		575,828	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	2,297,756		2,297,756	0	0	90.01
90.02	09002	SURGICAL CLINIC	382,894		382,894	0	0	90.02
90.03	09003	OP CLINIC	0		0	0	0	90.03
91.00	09100	EMERGENCY	2,432,315		2,432,315	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	364,920		364,920		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,359,856		1,359,856	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,699,576	0	29,699,576	0	0	200.00
201.00		Less Observation Beds	364,920		364,920		0	201.00
202.00		Total (see instructions)	29,334,656	0	29,334,656	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 10:42 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,467,774		3,467,774			30.00
31.00	03100	INTENSIVE CARE UNIT	71,806		71,806			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,276,629	6,091,683	13,368,312	0.179234	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,015,014	1,474,400	2,489,414	0.029561	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	708,416	12,652,092	13,360,508	0.177100	0.000000	54.00
60.00	06000	LABORATORY	1,136,684	9,360,511	10,497,195	0.192848	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	315,409	1,805,313	2,120,722	0.475720	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	773,912	2,805,326	3,579,238	0.485731	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,935,822	1,025,251	2,961,073	0.520587	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,294,217	520,785	6,815,002	0.534212	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,642,689	5,271,136	6,913,825	0.380070	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	548,241	548,241			88.00
90.00	09000	CLINIC	24	528,135	528,159	1.090255	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	463	1,547,786	1,548,249	1.484100	0.000000	90.01
90.02	09002	SURGICAL CLINIC	52	208,503	208,555	1.835938	0.000000	90.02
90.03	09003	OP CLINIC	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	48,241	4,409,422	4,457,663	0.545648	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,404	258,401	267,805	1.362633	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,895,477	1,895,477	0.717422	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,696,556	50,402,462	75,099,018			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	24,696,556	50,402,462	75,099,018			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 10:42 am

Title XVIII | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		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 PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000		90.01
90.02	09002	SURGICAL CLINIC	0.000000		90.02
90.03	09003	OP CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 10:42 am

Title XIX | Hospital

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,923,810		3,923,810	0	3,923,810	30.00
31.00	03100	INTENSIVE CARE UNIT	486,821		486,821	0	486,821	31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,396,057		2,396,057	0	2,396,057	50.00
53.00	05300	ANESTHESIOLOGY	73,590		73,590	0	73,590	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,366,146		2,366,146	0	2,366,146	54.00
60.00	06000	LABORATORY	2,024,361		2,024,361	0	2,024,361	60.00
65.00	06500	RESPIRATORY THERAPY	1,008,870	0	1,008,870	0	1,008,870	65.00
66.00	06600	PHYSICAL THERAPY	1,738,548	0	1,738,548	0	1,738,548	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,541,495		1,541,495	0	1,541,495	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	3,640,654		3,640,654	0	3,640,654	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,627,740		2,627,740	0	2,627,740	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	457,915		457,915	0	457,915	88.00
90.00	09000	CLINIC	575,828		575,828	0	575,828	90.00
90.01	09001	ORTHOPAEDIC CLINIC	2,297,756		2,297,756	0	2,297,756	90.01
90.02	09002	SURGICAL CLINIC	382,894		382,894	0	382,894	90.02
90.03	09003	OP CLINIC	0		0	0	0	90.03
91.00	09100	EMERGENCY	2,432,315		2,432,315	0	2,432,315	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	364,920		364,920		364,920	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,359,856		1,359,856	0	1,359,856	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	29,699,576	0	29,699,576	0	29,699,576	200.00
201.00		Less Observation Beds	364,920		364,920		364,920	201.00
202.00		Total (see instructions)	29,334,656	0	29,334,656	0	29,334,656	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 10:42 am

Title XIX | Hospital

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,467,774		3,467,774			30.00
31.00	03100	INTENSIVE CARE UNIT	71,806		71,806			31.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,276,629	6,091,683	13,368,312	0.179234	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	1,015,014	1,474,400	2,489,414	0.029561	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	708,416	12,652,092	13,360,508	0.177100	0.000000	54.00
60.00	06000	LABORATORY	1,136,684	9,360,511	10,497,195	0.192848	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	315,409	1,805,313	2,120,722	0.475720	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	773,912	2,805,326	3,579,238	0.485731	0.000000	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,935,822	1,025,251	2,961,073	0.520587	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	6,294,217	520,785	6,815,002	0.534212	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,642,689	5,271,136	6,913,825	0.380070	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	548,241	548,241	0.835244	0.000000	88.00
90.00	09000	CLINIC	24	528,135	528,159	1.090255	0.000000	90.00
90.01	09001	ORTHOPAEDIC CLINIC	463	1,547,786	1,548,249	1.484100	0.000000	90.01
90.02	09002	SURGICAL CLINIC	52	208,503	208,555	1.835938	0.000000	90.02
90.03	09003	OP CLINIC	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	48,241	4,409,422	4,457,663	0.545648	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	9,404	258,401	267,805	1.362633	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	1,895,477	1,895,477	0.717422	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	24,696,556	50,402,462	75,099,018			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	24,696,556	50,402,462	75,099,018			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet C Part I Date/Time Prepared: 5/24/2016 10:42 am

Title XIX | Hospital

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
		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 PATIENT	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000		90.01
90.02	09002	SURGICAL CLINIC	0.000000		90.02
90.03	09003	OP CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		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: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part II Date/Time Prepared: 5/24/2016 10:42 am

Title XVIII | Hospital | Cost

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	332,953	13,368,312	0.024906	3,929,151	97,859	50.00
53.00	05300	ANESTHESIOLOGY	0	2,489,414	0.000000	529,157	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	111,290	13,360,508	0.008330	412,350	3,435	54.00
60.00	06000	LABORATORY	79,079	10,497,195	0.007533	848,836	6,394	60.00
65.00	06500	RESPIRATORY THERAPY	35,461	2,120,722	0.016721	272,014	4,548	65.00
66.00	06600	PHYSICAL THERAPY	245,672	3,579,238	0.068638	421,907	28,959	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	45,580	2,961,073	0.015393	1,019,949	15,700	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	16,789	6,815,002	0.002464	3,469,674	8,549	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	31,816	6,913,825	0.004602	795,160	3,659	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	36,230	548,241	0.066084	0	0	88.00
90.00	09000	CLINIC	75,601	528,159	0.143141	23	3	90.00
90.01	09001	ORTHOPAEDIC CLINIC	259,769	1,548,249	0.167782	388	65	90.01
90.02	09002	SURGICAL CLINIC	2,692	208,555	0.012908	52	1	90.02
90.03	09003	OP CLINIC	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	98,070	4,457,663	0.022000	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	37,406	267,805	0.139676	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	1,408,408	69,663,961		11,698,661	169,172	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/24/2016 10:42 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	73,590	0	0	0	73,590	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	0	0	0	0	0	90.02
90.03	09003	OP CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	73,590	0	0	0	73,590	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/24/2016 10:42 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	13,368,312	0.000000	0.000000	3,929,151	50.00
53.00	05300	ANESTHESIOLOGY	0	2,489,414	0.029561	0.000000	529,157	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,360,508	0.000000	0.000000	412,350	54.00
60.00	06000	LABORATORY	0	10,497,195	0.000000	0.000000	848,836	60.00
65.00	06500	RESPIRATORY THERAPY	0	2,120,722	0.000000	0.000000	272,014	65.00
66.00	06600	PHYSICAL THERAPY	0	3,579,238	0.000000	0.000000	421,907	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,961,073	0.000000	0.000000	1,019,949	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	6,815,002	0.000000	0.000000	3,469,674	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	6,913,825	0.000000	0.000000	795,160	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	548,241	0.000000	0.000000	0	88.00
90.00	09000	CLINIC	0	528,159	0.000000	0.000000	23	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	1,548,249	0.000000	0.000000	388	90.01
90.02	09002	SURGICAL CLINIC	0	208,555	0.000000	0.000000	52	90.02
90.03	09003	OP CLINIC	0	0	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	4,457,663	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	267,805	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	69,663,961			11,698,661	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part IV | Date/Time Prepared: 5/24/2016 10:42 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	15,642	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 PATIENT	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0	0		90.02
90.03	09003	OP CLINIC	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	15,642	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/24/2016 10:42 am

Title XVIII | Hospital | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.179234	0	1,251,986	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.029561	0	277,498	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177100	0	4,761,396	0	0	54.00
60.00	06000	LABORATORY	0.192848	0	4,405,024	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.475720	0	541,808	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.485731	0	866,599	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.520587	0	266,883	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.534212	0	71,524	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.380070	0	3,025,434	9,457	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
90.00	09000	CLINIC	1.090255	0	31,798	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.484100	0	527,903	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.835938	0	71,110	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.545648	0	1,389,970	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.362633	0	190,642	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.717422		0			95.00
200.00		Subtotal (see instructions)		0	17,679,575	9,457	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	17,679,575	9,457	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/24/2016 10:42 am

Title XVIII | Hospital | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	224,398	0		50.00
53.00	05300	ANESTHESIOLOGY	8,203	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	843,243	0		54.00
60.00	06000	LABORATORY	849,500	0		60.00
65.00	06500	RESPIRATORY THERAPY	257,749	0		65.00
66.00	06600	PHYSICAL THERAPY	420,934	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	138,936	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	38,209	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,149,877	3,594		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	34,668	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	783,461	0		90.01
90.02	09002	SURGICAL CLINIC	130,554	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	758,434	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	259,775	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	5,897,941	3,594		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	5,897,941	3,594		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141327 | Component CCN: 14Z327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/24/2016 10:42 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.179234	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.029561	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177100	0	0	0	0	54.00
60.00	06000	LABORATORY	0.192848	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.475720	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.485731	0	0	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.520587	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.534212	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.380070	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	1.090255	0	0	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.484100	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.835938	0	0	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.545648	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.362633	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.717422		0			95.00
200.00		Subtotal (see instructions)		0	0	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141327 | Component CCN: 14Z327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V | Date/Time Prepared: 5/24/2016 10:42 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
60.00	06000	LABORATORY	0	0		60.00
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 PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/24/2016 10:42 am

Title XIX | Hospital

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.179234	0	1,219,026	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.029561	0	616,213	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177100	0	2,755,830	0	0	54.00
60.00	06000	LABORATORY	0.192848	0	1,458,299	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.475720	0	267,352	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.485731	0	411,346	0	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.520587	0	322,170	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.534212	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.380070	0	647,244	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.835244				0	88.00
90.00	09000	CLINIC	1.090255	0	80,892	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.484100	0	0	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.835938	0	0	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.545648	0	1,374,151	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.362633	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.717422	0	340,184			95.00
200.00		Subtotal (see instructions)		0	9,492,707	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		0	9,492,707	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D Part V Date/Time Prepared: 5/24/2016 10:42 am

Title XIX | Hospital

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	218,491	0		50.00
53.00	05300	ANESTHESIOLOGY	18,216	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	488,057	0		54.00
60.00	06000	LABORATORY	281,230	0		60.00
65.00	06500	RESPIRATORY THERAPY	127,185	0		65.00
66.00	06600	PHYSICAL THERAPY	199,804	0		66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	167,718	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	245,998	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
90.00	09000	CLINIC	88,193	0		90.00
90.01	09001	ORTHOPAEDIC CLINIC	0	0		90.01
90.02	09002	SURGICAL CLINIC	0	0		90.02
90.03	09003	OP CLINIC	0	0		90.03
91.00	09100	EMERGENCY	749,803	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	244,055			95.00
200.00		Subtotal (see instructions)	2,828,750	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	2,828,750	0		202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 10:42 am

Title XVIII | Hospital | Cost

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,948	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,653	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)	2,384	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	232	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	63	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)	1,710	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)	232	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	160.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	160.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,923,810	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)	10,080	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)	324,807	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,599,003	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,599,003	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,356.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,319,752	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,319,752	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 10:42 am

Title XVIII | Hospital | Cost

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	486,821	85	5,727.31	47	269,184	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	3,978,363	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	6,567,299	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)	314,727	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)	314,727	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	269	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,356.58	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	364,920	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 10:42 am

Title XVIII | Hospital | Cost

	Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	368,920	3,599,003	0.102506	364,920	37,406	90.00
91.00	Nursing School cost	0	3,599,003	0.000000	364,920	0	91.00
92.00	Allied health cost	0	3,599,003	0.000000	364,920	0	92.00
93.00	All other Medical Education	0	3,599,003	0.000000	364,920	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 10:42 am

Title XIX | Hospital

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,948	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,653	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)	2,384	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	232	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	63	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)	168	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	63	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	90.06	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	90.06	20.00
21.00	Total general inpatient routine service cost (see instructions)	3,923,810	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)	5,674	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)	320,756	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3,603,054	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,603,054	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,358.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	228,162	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)	228,162	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 10:42 am

Title XIX | Hospital

	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	486,821	85	5,727.31	38	217,638	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	445,800	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)	445,800	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	5,674	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)	5,674	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	269	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,358.11	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	365,332	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-1 | Date/Time Prepared: 5/24/2016 10:42 am

Title XIX | Hospital

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/24/2016 10:42 am

Title XVIII | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,091,654		30.00
31.00	03100	INTENSIVE CARE UNIT		43,088		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.179234	3,929,151	704,237	50.00
53.00	05300	ANESTHESIOLOGY	0.029561	529,157	15,642	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177100	412,350	73,027	54.00
60.00	06000	LABORATORY	0.192848	848,836	163,696	60.00
65.00	06500	RESPIRATORY THERAPY	0.475720	272,014	129,403	65.00
66.00	06600	PHYSICAL THERAPY	0.485731	421,907	204,933	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.520587	1,019,949	530,972	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.534212	3,469,674	1,853,541	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.380070	795,160	302,216	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.090255	23	25	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.484100	388	576	90.01
90.02	09002	SURGICAL CLINIC	1.835938	52	95	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.545648	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.362633	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		11,698,661	3,978,363	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		11,698,661		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141327 | Component CCN: 14Z327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/24/2016 10:42 am

Title XVIII | Swing Beds - SNF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.179234	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.029561	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.177100	14,260	2,525	54.00
60.00	06000	LABORATORY	0.192848	36,745	7,086	60.00
65.00	06500	RESPIRATORY THERAPY	0.475720	26,076	12,405	65.00
66.00	06600	PHYSICAL THERAPY	0.485731	103,729	50,384	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.520587	29,015	15,105	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.534212	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.380070	74,202	28,202	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
90.00	09000	CLINIC	1.090255	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	1.484100	0	0	90.01
90.02	09002	SURGICAL CLINIC	1.835938	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.545648	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1.362633	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		284,027	115,707	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		284,027		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet D-3 | Date/Time Prepared: 5/24/2016 10:42 am

Title XIX | Hospital

		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		256,709		30.00
31.00	03100	INTENSIVE CARE UNIT		9,844		31.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	534,949	0	50.00
53.00	05300	ANESTHESIOLOGY	0.000000	180,295	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	43,613	0	54.00
60.00	06000	LABORATORY	0.000000	77,648	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	16,755	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	41,694	0	66.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	687,681	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0.000000	119,294	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	88.00
90.00	09000	CLINIC	0.000000	0	0	90.00
90.01	09001	ORTHOPAEDIC CLINIC	0.000000	0	0	90.01
90.02	09002	SURGICAL CLINIC	0.000000	0	0	90.02
90.03	09003	OP CLINIC	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.000000	2,037	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		1,703,966	0	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,703,966		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141327	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/24/2016 10:42 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	5,901,535	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	5,901,535	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	5,960,550	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)	53,800	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	2,690,757	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,215,993	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	3,215,993	30.00
31.00	Primary payer payments	3,231	31.00
32.00	Subtotal (line 30 minus line 31)	3,212,762	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)	297,801	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	193,571	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	297,801	36.00
37.00	Subtotal (see instructions)	3,406,333	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3,406,333	40.00
40.01	Sequestration adjustment (see instructions)	68,127	40.01
41.00	Interim payments	3,244,694	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	93,512	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: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I Date/Time Prepared: 5/24/2016 10:42 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		4,928,692		3,601,765	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		26,072		227,121	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	09/01/2015	141,491		0	3.01
3.02		12/15/2015	816,462		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	09/01/2015	127,040	3.50
3.51			0	12/15/2015	457,152	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)		957,953		-584,192	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,912,717		3,244,694	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		167,170		93,512	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,079,887		3,338,206	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: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet E-1 Part I | Date/Time Prepared: 5/24/2016 10:42 am

Component CCN: 14Z327 | 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		399,645		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	09/01/2015	21,814		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)		21,814		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)		421,459		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		1,651		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		423,110		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: 141327	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part II Date/Time Prepared: 5/24/2016 10:42 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	712	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	1,757	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	13	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	2,469	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	75,099,018	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	75,305	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	0	8.00
9.00	Sequestration adjustment amount (see instructions)	0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 141327 Component CCN: 14Z327	Period: From 01/01/2015 To 12/31/2015	Worksheet E-2 Date/Time Prepared: 5/24/2016 10:42 am
	Title XVIII	Swing Beds - SNF	Cost

		Part A	Part B	
		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient routine services - swing bed-SNF (see instructions)	317,874	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)	116,864	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	232	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)	434,738	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	434,738	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)	434,738	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	2,993	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)	431,745	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)	431,745	0	19.00
19.01	Sequestration adjustment (see instructions)	8,635	0	19.01
20.00	Interim payments	421,459	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)	1,651	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141327	Period: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prepared: 5/24/2016 10:42 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	6,567,299	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	6,567,299	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	6,632,972	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routine service charges	0	7.00
8.00	Ancillary service charges	0	8.00
9.00	Organ acquisition charges, net of revenue	0	9.00
10.00	Total reasonable charges	0	10.00
	Customary charges		
11.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00
14.00	Total customary charges (see instructions)	0	14.00
15.00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)	0	15.00
16.00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)	0	16.00
17.00	Cost of physicians' services in a teaching hospital (see instructions)	0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	6,632,972	19.00
20.00	Deductibles (exclude professional component)	458,552	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	6,174,420	22.00
23.00	Coinsurance	315	23.00
24.00	Subtotal (line 22 minus line 23)	6,174,105	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	45,940	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	29,861	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	45,940	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	6,203,966	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)	6,203,966	30.00
30.01	Sequestration adjustment (see instructions)	124,079	30.01
31.00	Interim payments	5,912,717	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)	167,170	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: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G | Date/Time Prepared: 5/24/2016 10:42 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	4,731,529	0	0	0	1.00
2.00	Temporary investments	5,424,915	0	0	0	2.00
3.00	Notes receivable	18,529	0	0	0	3.00
4.00	Accounts receivable	15,399,628	0	0	0	4.00
5.00	Other receivable	6,566	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-7,330,485	0	0	0	6.00
7.00	Inventory	816,117	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	733,020	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	19,799,819	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	38,762,696	0	0	0	15.00
16.00	Accumulated depreciation	-22,333,734	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	16,428,962	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	643,275	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	643,275	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	36,872,056	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	578,090	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,155,821	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,517,378	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	4,286,474	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	8,537,763	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	5,480,000	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	5,480,000	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	14,017,763	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	22,854,293				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)	22,854,293	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	36,872,056	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-1 | Date/Time Prepared: 5/24/2016 10:42 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		20,754,954		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,099,339				2.00
3.00	Total (sum of line 1 and line 2)		22,854,293		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)		22,854,293		0		11.00
12.00		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)		22,854,293		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			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: 141327 | Period: From 01/01/2015 To 12/31/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 5/24/2016 10:42 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	3,735,579		3,735,579	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3,735,579		3,735,579	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	71,806		71,806	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)	71,806		71,806	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,807,385		3,807,385	17.00
18.00	Ancillary services	22,234,337	46,966,628	69,200,965	18.00
19.00	Outpatient services	0	611,467	611,467	19.00
20.00	RURAL HEALTH CLINIC	0	548,241	548,241	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	1,895,477	1,895,477	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PRO FEES	8,557	10,307,296	10,315,853	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	26,050,279	60,329,109	86,379,388	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		36,721,277		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	NON-OPERATING EXPENSES	4,729,948			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)		4,729,948		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		31,991,329		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 141327	Period: From 01/01/2015 To 12/31/2015	Worksheet G-3 Date/Time Prepared: 5/24/2016 10:42 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	86,379,388	1.00
2.00	Less contractual allowances and discounts on patients' accounts	48,616,836	2.00
3.00	Net patient revenues (line 1 minus line 2)	37,762,552	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	31,991,329	4.00
5.00	Net income from service to patients (line 3 minus line 4)	5,771,223	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING REVENUE	667,035	24.00
24.01	NON-OPERATING DEDUCTIONS	4,707,138	24.01
25.00	Total other income (sum of lines 6-24)	5,374,173	25.00
26.00	Total (line 5 plus line 25)	11,145,396	26.00
27.00	NON-OPERATING G/L	147,264	27.00
27.01	NON-OPERATIN DEDUCTIONS	8,898,793	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	9,046,057	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,099,339	29.00

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

Provider CCN: 141327 Component CCN: 148501 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/24/2016 10:42 am

Rural Health Clinic (RHC) I | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	0	0	0	0	0	1.00
2.00	Physician Assistant	116,384	0	116,384	0	116,384	2.00
3.00	Nurse Practitioner	12,462	0	12,462	0	12,462	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	64,933	0	64,933	0	64,933	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)	193,779	0	193,779	0	193,779	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	6,269	6,269	-1,733	4,536	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	6,269	6,269	-1,733	4,536	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	193,779	6,269	200,048	-1,733	198,315	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	23,966	23,966	0	23,966	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	23,966	23,966	0	23,966	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	193,779	30,235	224,014	-1,733	222,281	32.00

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

Provider CCN: 141327 | Component CCN: 148501 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-1 | Date/Time Prepared: 5/24/2016 10:42 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	0		1.00
2.00	Physician Assistant	0	116,384		2.00
3.00	Nurse Practitioner	0	12,462		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	64,933		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	193,779		10.00
11.00	Physician Services Under Agreement	0	0		11.00
12.00	Physician Supervision Under Agreement	0	0		12.00
13.00	Other Costs Under Agreement	0	0		13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		14.00
15.00	Medical Supplies	0	4,536		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	4,536		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	0	198,315		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23.00	Pharmacy	0	0		23.00
24.00	Dental	0	0		24.00
25.00	Optometry	0	0		25.00
26.00	All other nonreimbursable costs	0	0		26.00
27.00	Nonallowable GME costs	0	0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0		28.00
	FACILITY OVERHEAD				
29.00	Facility Costs	0	0		29.00
30.00	Administrative Costs	0	23,966		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	23,966		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	0	222,281		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141327 | Component CCN: 148501 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-2 | Date/Time Prepared: 5/24/2016 10:42 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	0.00	15	4,200	0		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	1.11	5,289	2,100	2,331		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.11	5,304		2,331	5,304	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.11	5,304			5,304	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					198,315	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)					198,315	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)					23,966	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					235,634	15.00
16.00	Total overhead (sum of lines 14 and 15)					259,600	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					259,600	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					259,600	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					457,915	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141327 | Component CCN: 148501 | Period: From 01/01/2015 To 12/31/2015 | Worksheet M-3 | Date/Time Prepared: 5/24/2016 10:42 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)		457,915	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		0	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		457,915	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		5,304	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)		5,304	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		86.33	7.00
		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	80.44	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	86.33	86.33	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	326	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	28,144	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) *		28,144	16.00
16.01	Total program charges (see instructions)(from contractor's records)		43,776	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		0	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		0	16.03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03 and 18) times .80) (Titles V and XIX see instructions.)		18,516	16.04
16.05	Total program cost (see instructions)		18,516	16.05
17.00	Primary payer amounts		64	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		4,999	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		7,755	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		18,452	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		0	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		18,452	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)		18,452	26.00
26.01	Sequestration adjustment (see instructions)		369	26.01
27.00	Interim payments		16,298	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)		1,785	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 141327 Component CCN: 148501	Period: From 01/01/2015 To 12/31/2015	Worksheet M-5 Date/Time Prepared: 5/24/2016 10:42 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		16,298	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		16,298	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		1,785	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		18,083	7.00

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