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: 141329	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 10/27/2015 1:04 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 10/27/2015 Time: 1:04 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 MORRISON COMMUNITY HOSPITAL (141329) for the cost reporting period beginning 07/01/2014 and ending 06/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-10,251	-120,229	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	-38,673	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
10.00	RURAL HEALTH CLINIC I	0		42,525		0	10.00
200.00	Total	0	-48,924	-77,704	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: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 10/27/2015 8:26 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 303 JACKSON	PO Box:			1.00
2.00	City: MORRISON	State: IL	Zip Code: 61270	County: WHITESIDE	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	MORRISON COMMUNITY HOSPITAL	141329	99914	1	08/01/2003	N	O	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF	MORRISON SWING BED	14Z329	99914		08/01/2003	N	O	N	7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	MORRISON SNF	145274	99914		08/13/1974	N	P	O	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	MORRISON COMMUNITY HOSPITAL CLINIC	143981	99914		07/01/1996	N	O	O	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:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2014	06/30/2015	20.00
21.00	Type of Control (see instructions)	11		21.00
	Inpatient PPS Information			
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or “N” for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	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: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 10/27/2015 8:26 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 in effect in the cost reporting period.	0		37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, § 2148? If yes, complete Wkst. D-5.	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: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 10/27/2015 8:26 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: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 10/27/2015 8:26 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, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions)			0	76.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 10/27/2015 8:26 am

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	Y		106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I &R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes complete Wkst. D-2, Pt. II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	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, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	255,624	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 10/27/2015 8:26 am

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

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

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

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

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

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	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
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 141329	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 10/27/2015 8:26 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 10/27/2015 8:26 am

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

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

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	09/21/2015	Y	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: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 10/27/2015 8:26 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				Y	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				Y	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				Y	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				N	33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				Y	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAN	LINHART	41.00
42.00	Enter the employer/company name of the cost report preparer.	MCGLADREY LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	563-888-4404	DAN.LINHART@MCGLADREY.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part II | Date/Time Prepared: 10/27/2015 8:26 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)				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)	09/21/2015			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.				18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.				19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:				20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.				21.00
			3.00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		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: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 10/27/2015 8:26 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	9,125	4,536.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9,125	4,536.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9,125	4,536.00	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	44.00	0	10,754		0	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: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 10/27/2015 8:26 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)	118	23	189			1.00
2.00	HMO and other (see instructions)	10	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	1,923	0	2,223			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	564			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2,041	23	2,976			7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	2,041	23	2,976	0.00	105.19	14.00
15.00	CAH visits	2,007	1,168	5,811			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	3,007	9,369	0.00	14.69	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,710	4,535	14,492	0.00	13.29	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00	Total (sum of lines 14-26)				0.00	133.17	27.00
28.00	Observation Bed Days		18	77			28.00
29.00	Ambulance Trips	289					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: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I | Date/Time Prepared: 10/27/2015 8:26 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	36	10	66	1.00
2.00	HMO and other (see instructions)			4	0		2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	36	10	66	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	0.00					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

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-7 | Date/Time Prepared: 10/27/2015 8:26 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	Y		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	08/01/2003	2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	0	0	0	12.00
13.00		RUB	0	0	0	13.00
14.00		RUA	0	0	0	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	0	0	0	16.00
17.00		RVA	0	0	0	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	0	0	0	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	0	0	0	22.00
23.00		RMA	0	0	0	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	0	0	0	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	0	0	0	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-7 | Date/Time Prepared: 10/27/2015 8:26 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	0	0	0	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		0	0	0	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	99914		201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	690,294	39.72	Y	202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	0	0.00		205.00
206.00	OTHER (SPECIFY)	0	0.00		206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	1,737,766			207.00

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

Provider CCN: 141329 Component CCN: 143981 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-8 | Date/Time Prepared: 10/27/2015 8:26 am

					Rural Health Clinic (RHC) I	Cost	
					1.00		
	Clinic Address and Identification						
1.00	Street				300 NORTH JACKSON STREET		1.00
			City		State	Zip Code	
			1.00		2.00	3.00	
2.00	City, State, Zip Code, County		MORRISON		IL	61270	2.00
						1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban					0	3.00
					Grant Award	Date	
					1.00	2.00	
	Source of Federal Funds						
4.00	Community Health Center (Section 330(d), PHS Act)				0		4.00
5.00	Migrant Health Center (Section 329(d), PHS Act)				0		5.00
6.00	Health Services for the Homeless (Section 340(d), PHS Act)				0		6.00
7.00	Appalachian Regional Commission				0		7.00
8.00	Look-Alikes				0		8.00
9.00	OTHER (SPECIFY)				0		9.00
					1.00	2.00	
10.00	Does this facility operate as other than an RHC or FQHC? Enter "Y" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2.(Enter in subscripts of line 11 the type of other operation(s) and the operating hours.)				N	0	10.00
		Sunday		Monday		Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic	08:00	20:00	08:00	20:00	08:00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception to the productivity standard?				N		12.00
13.00	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.				N	0	13.00
				Provider name		CCN number	
				1.00		2.00	
14.00	Provider name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		0	0	0	0	15.00
			County				
			4.00				
2.00	City, State, Zip Code, County		WHITESIDE				2.00
		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	20:00	08:00	20:00	08:00	20:00	11.00

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

Provider CCN: 141329
Component CCN: 143981

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

Worksheet S-8

Date/Time Prepared: 10/27/2015 8:26 am

Rural Health Clinic (RHC) I

Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	20:00	08:00	20:00		11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 10/27/2015 8:26 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)	0.801555	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	1,689,128	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	3,325,775	6.00
7.00	Medicaid cost (line 1 times line 6)	2,665,792	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)	976,664	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)	976,664	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	35,841	14,818	50,659	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	28,729	11,877	40,606	21.00
22.00	Partial payment by patients approved for charity care	2,015	4,068	6,083	22.00
23.00	Cost of charity care (line 21 minus line 22)	26,714	7,809	34,523	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)	776,001	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	48,720	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	727,281	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	582,956	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	617,479	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	1,594,143	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 10/27/2015 8:26 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		644,759	644,759	-314,234	330,525	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		53,818	53,818	465,071	518,889	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,254,821	1,254,821	-74,278	1,180,543	4.00
5.01	00560	PURCHASING	47,567	3,910	51,477	0	51,477	5.01
5.02	00591	PERSONNEL	100,491	18,456	118,947	0	118,947	5.02
5.03	00580	HOSPITAL BILLING	279,542	80,140	359,682	0	359,682	5.03
5.04	00592	NURSING HOME BILLING	426	126	552	0	552	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	410,350	507,928	918,278	199,198	1,117,476	5.05
7.00	00700	OPERATION OF PLANT	162,587	375,505	538,092	0	538,092	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,819	34,819	0	34,819	8.00
9.00	00900	HOUSEKEEPING	174,314	30,098	204,412	0	204,412	9.00
10.00	01000	DIETARY	197,318	111,347	308,665	0	308,665	10.00
11.00	01100	CAFETERIA	0	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	154,949	4,939	159,888	0	159,888	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	16,622	20,620	37,242	0	37,242	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	213,382	32,296	245,678	0	245,678	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	158	24	182	0	182	16.01
17.00	01700	SOCIAL SERVICE	68,763	266	69,029	0	69,029	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,212,641	138,494	1,351,135	1,081	1,352,216	30.00
44.00	04400	SKILLED NURSING FACILITY	501,611	26,443	528,054	-4,594	523,460	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,679	161,103	197,782	-1,859	195,923	50.00
53.00	05300	ANESTHESIOLOGY	0	44,173	44,173	0	44,173	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	233,663	73,589	307,252	5,136	312,388	54.00
60.00	06000	LABORATORY	328,690	311,192	639,882	0	639,882	60.00
64.00	06400	INTRAVENOUS THERAPY	0	29,561	29,561	17,177	46,738	64.00
65.00	06500	RESPIRATORY THERAPY	519	37,078	37,597	-9,149	28,448	65.00
66.00	06600	PHYSICAL THERAPY	252,759	1,279	254,038	0	254,038	66.00
67.00	06700	OCCUPATIONAL THERAPY	191,082	1,391	192,473	0	192,473	67.00
68.00	06800	SPEECH PATHOLOGY	13,026	0	13,026	0	13,026	68.00
69.00	06900	ELECTROCARDIOLOGY	0	6,701	6,701	0	6,701	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,552	14,552	16,108	30,660	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,217	1,217	1,859	3,076	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	128,416	247,698	376,114	0	376,114	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,218,038	1,120,567	2,338,605	-534,782	1,803,823	88.00
91.00	09100	EMERGENCY	421,309	776,968	1,198,277	335,293	1,533,570	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	14,175	9,910	24,085	0	24,085	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	69,987	46,986	116,973	-8,757	108,216	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE		93,270	93,270	-93,270	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,449,064	6,316,044	12,765,108	0	12,765,108	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	813	5,975	6,788	0	6,788	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		TOTAL (SUM OF LINES 118-199)	6,449,877	6,322,019	12,771,896	0	12,771,896	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 10/27/2015 8:26 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-1,321	329,204		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-222,024	296,865		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-3,399	1,177,144		4.00
5.01	00560	PURCHASING	0	51,477		5.01
5.02	00591	PERSONNEL	0	118,947		5.02
5.03	00580	HOSPITAL BILLING	-12,128	347,554		5.03
5.04	00592	NURSING HOME BILLING	0	552		5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	-37,698	1,079,778		5.05
7.00	00700	OPERATION OF PLANT	0	538,092		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	34,819		8.00
9.00	00900	HOUSEKEEPING	0	204,412		9.00
10.00	01000	DIETARY	-27,995	280,670		10.00
11.00	01100	CAFETERIA	0	0		11.00
13.00	01300	NURSING ADMINISTRATION	0	159,888		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	37,242		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,213	242,465		16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	182		16.01
17.00	01700	SOCIAL SERVICE	0	69,029		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,139	1,351,077		30.00
44.00	04400	SKILLED NURSING FACILITY	0	523,460		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-42,738	153,185		50.00
53.00	05300	ANESTHESIOLOGY	-462	43,711		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-9,080	303,308		54.00
60.00	06000	LABORATORY	-37,070	602,812		60.00
64.00	06400	INTRAVENOUS THERAPY	0	46,738		64.00
65.00	06500	RESPIRATORY THERAPY	-82	28,366		65.00
66.00	06600	PHYSICAL THERAPY	-8,850	245,188		66.00
67.00	06700	OCCUPATIONAL THERAPY	-5,526	186,947		67.00
68.00	06800	SPEECH PATHOLOGY	0	13,026		68.00
69.00	06900	ELECTROCARDIOLOGY	-6,070	631		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-378	30,282		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,076		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	-1,800	374,314		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-54,663	1,749,160		88.00
91.00	09100	EMERGENCY	-105,840	1,427,730		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
93.00	04950	WOUND CARE	0	24,085		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-1,529	106,687		95.00
		SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE	0	0		113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-583,005	12,182,103		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
194.00	07950	OPTH CLINIC	0	6,788		194.00
194.01	07951	RENTAL SPACE	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0		194.02
200.00		TOTAL (SUM OF LINES 118-199)	-583,005	12,188,891		200.00

RECLASSIFICATIONS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 10/27/2015 8:26 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	79,125		1.00
2.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	7,723		2.00
3.00	AMBULANCE SERVICES	95.00	0	1,286		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,136		4.00
	TOTALS		0	93,270		
	B - INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	56,701		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,011		2.00
3.00	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	191,475		3.00
	TOTALS		0	263,187		
	C - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	450,060		1.00
	TOTALS		0	450,060		
	D - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	1,859		1.00
	TOTALS		0	1,859		
	E - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	16,108		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	TOTALS		0	16,108		
	F - ACTIVITIES DIRECTOR					
1.00	ADULTS & PEDIATRICS	30.00	3,354	96		1.00
	TOTALS		3,354	96		
	G - RHC PHYS IN ER					
1.00	EMERGENCY	91.00	0	463,062		1.00
	TOTALS		0	463,062		
	H - IV THERAPY SALARIES					
1.00	INTRAVENOUS THERAPY	64.00	17,177	0		1.00
	TOTALS		17,177	0		
	I - PHYSICIAN BENEFITS					
1.00	RURAL HEALTH CLINIC	88.00	0	74,278		1.00
	TOTALS		0	74,278		
500.00	Grand Total: Increases		20,531	1,361,920		500.00

RECLASSIFICATIONS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 10/27/2015 8:26 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	93,270	11		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS		0	93,270			
	B - INSURANCE						
1.00	EMERGENCY	91.00	0	107,146	12		1.00
2.00	RURAL HEALTH CLINIC	88.00	0	145,998	12		2.00
3.00	AMBULANCE SERVICES	95.00	0	10,043	0		3.00
	TOTALS		0	263,187			
	C - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	450,060	9		1.00
	TOTALS		0	450,060			
	D - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	1,859	0		1.00
	TOTALS		0	1,859			
	E - MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	2,369	0		1.00
2.00	SKILLED NURSING FACILITY	44.00	0	1,144	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	9,149	0		3.00
4.00	EMERGENCY	91.00	0	3,446	0		4.00
	TOTALS		0	16,108			
	F - ACTIVITIES DIRECTOR						
1.00	SKILLED NURSING FACILITY	44.00	3,354	96	0		1.00
	TOTALS		3,354	96			
	G - RHC PHYS IN ER						
1.00	RURAL HEALTH CLINIC	88.00	0	463,062	0		1.00
	TOTALS		0	463,062			
	H - IV THERAPY SALARIES						
1.00	EMERGENCY	91.00	17,177	0	0		1.00
	TOTALS		17,177	0			
	I - PHYSICIAN BENEFITS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	74,278	0		1.00
	TOTALS		0	74,278			
500.00	Grand Total: Decreases		20,531	1,361,920			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I | Date/Time Prepared: 10/27/2015 8:26 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	21,657	188,490	0	188,490	0	1.00
2.00	Land Improvements	362,300	0	0	0	0	2.00
3.00	Buildings and Fixtures	4,478,036	169,011	0	169,011	0	3.00
4.00	Building Improvements	3,338,798	340,553	0	340,553	0	4.00
5.00	Fixed Equipment	328,274	892	0	892	0	5.00
6.00	Movable Equipment	4,085,108	1,188,967	0	1,188,967	431,802	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	12,614,173	1,887,913	0	1,887,913	431,802	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	12,614,173	1,887,913	0	1,887,913	431,802	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	210,147	0	1.00
2.00	Land Improvements	362,300	0	2.00
3.00	Buildings and Fixtures	4,647,047	0	3.00
4.00	Building Improvements	3,679,351	0	4.00
5.00	Fixed Equipment	329,166	0	5.00
6.00	Movable Equipment	4,842,273	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	14,070,284	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	14,070,284	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II Date/Time Prepared: 10/27/2015 8:26 am

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	644,759	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	53,818	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	698,577	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	644,759	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	53,818	2.00
3.00	Total (sum of lines 1-2)	0	698,577	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 10/27/2015 8:26 am

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	9,228,011	0	9,228,011	0.655851	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4,842,273	0	4,842,273	0.344149	0	2.00
3.00	Total (sum of lines 1-2)	14,070,284	0	14,070,284	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	194,699	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	281,854	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	476,553	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	77,804	56,701	0	0	329,204	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	15,011	0	0	296,865	2.00
3.00	Total (sum of lines 1-2)	77,804	71,712	0	0	626,069	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 10/27/2015 8:26 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-1,321	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-3,224	OTHER ADMINISTRATIVE AND GENERAL	5.05	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	-158,109			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-26,106	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-3,213	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 10/27/2015 8:26 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	
32.00	CAH HIT Adjustment for Depreciation and Interest	A	-222,024	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
33.00	CATERING REVENUE	B	-1,158	DIETARY	10.00	0	33.00
33.01	PHARMACY OTHER REV	B	-300	DRUGS CHARGED TO PATIENTS	73.00	0	33.01
33.02	LAB OTHER REVENUE	B	-21,478	LABORATORY	60.00	0	33.02
33.03	REHAB MISC REV	B	-3,880	PHYSICAL THERAPY	66.00	0	33.03
33.04	INVESTMENT INCOME-OTHER	B	-129	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.04
33.05	INVESTMENT INCOME-OTHER	B	-21	AMBULANCE SERVICES	95.00	0	33.05
33.06	INVESTMENT INCOME-OTHER	B	-86	RADIOLOGY-DIAGNOSTIC	54.00	0	33.06
33.07	OTHER REV -A&G	B	-820	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	33.07
33.08	OTHER REV - DIETARY	B	-731	DIETARY	10.00	0	33.08
33.09	OTHER REV - AMBULANCE	B	-150	AMBULANCE SERVICES	95.00	0	33.09
34.00	NONALLOWABLE DUES	A	-4,990	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	34.00
35.00	PATIENT TELEPHONE - SALARIES	A	-5,340	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	35.00
36.00	PATIENT TELEPHONE - BENEFITS	A	-1,039	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	36.00
37.00	PHYSICIAN BILLING SALARIES	A	-12,128	HOSPITAL BILLING	5.03	0	37.00
38.00	PHYSICIAN BILLING EMPLOYEE BENEFITS	A	-2,360	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	38.00
39.00	ADVERTISING	A	-23,120	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	39.00
41.00	OTHER REV- EDUCATION	A	-75	OTHER ADMINISTRATIVE AND GENERAL	5.05	0	41.00
41.01	SELF INSURANCE EXPENSE	A	-1,139	ADULTS & PEDIATRICS	30.00	0	41.01
43.00	SELF INSURANCE EXPENSE	A	-8,567	OPERATING ROOM	50.00	0	43.00
44.00	SELF INSURANCE EXPENSE	A	-462	ANESTHESIOLOGY	53.00	0	44.00
45.00	SELF INSURANCE EXPENSE	A	-8,994	RADIOLOGY-DIAGNOSTIC	54.00	0	45.00
45.01	SELF INSURANCE EXPENSE	A	-14,430	LABORATORY	60.00	0	45.01
45.02	SELF INSURANCE EXPENSE	A	-1,162	LABORATORY	60.00	0	45.02
45.03	SELF INSURANCE EXPENSE	A	-82	RESPIRATORY THERAPY	65.00	0	45.03
45.04	SELF INSURANCE EXPENSE	A	-4,970	PHYSICAL THERAPY	66.00	0	45.04
45.06	SELF INSURANCE EXPENSE	A	-5,526	OCCUPATIONAL THERAPY	67.00	0	45.06
45.07	SELF INSURANCE EXPENSE	A	-103	ELECTROCARDIOLOGY	69.00	0	45.07
45.08	SELF INSURANCE EXPENSE	A	-378	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	45.08
45.09	SELF INSURANCE EXPENSE	A	-1,500	DRUGS CHARGED TO PATIENTS	73.00	0	45.09
45.11	SELF INSURANCE EXPENSE	A	-12,340	EMERGENCY	91.00	0	45.11
45.12	SELF INSURANCE EXPENSE	A	-30,192	RURAL HEALTH CLINIC	88.00	0	45.12
45.13	SELF INSURANCE EXPENSE	A	-1,358	AMBULANCE SERVICES	95.00	0	45.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-583,005				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 10/27/2015 8:26 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	91.00	EMERGENCY	992,724	93,500	899,224	0	0	1.00
2.00	91.00	EMERGENCY	8,400	0	8,400	0	0	2.00
3.00	50.00	OPERATING ROOM	34,171	34,171	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	5,967	5,967	0	0	0	4.00
5.00	88.00	RURAL HEALTH CLINIC	24,471	24,471	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,065,733	158,109	907,624		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	91.00	EMERGENCY	0	0	0	0	0	1.00
2.00	91.00	EMERGENCY	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	4.00
5.00	88.00	RURAL HEALTH CLINIC	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0	0	0	93,500		1.00
2.00	91.00	EMERGENCY	0	0	0	0		2.00
3.00	50.00	OPERATING ROOM	0	0	0	34,171		3.00
4.00	69.00	ELECTROCARDIOLOGY	0	0	0	5,967		4.00
5.00	88.00	RURAL HEALTH CLINIC	0	0	0	24,471		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	158,109		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 10/27/2015 8:26 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	PURCHASING	
			0	1.00	2.00	4.00	5.01	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	329,204	329,204				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	296,865		296,865			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,177,144	0	0	1,177,144		4.00
5.01	00560	PURCHASING	51,477	9,973	0	9,963	71,413	5.01
5.02	00591	PERSONNEL	118,947	2,982	0	21,049	196	5.02
5.03	00580	HOSPITAL BILLING	347,554	5,476	0	56,013	1,570	5.03
5.04	00592	NURSING HOME BILLING	552	554	0	89	0	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	1,079,778	16,786	68,318	84,834	5,297	5.05
7.00	00700	OPERATION OF PLANT	538,092	61,653	3,881	34,056	1,700	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	34,819	7,851	0	0	131	8.00
9.00	00900	HOUSEKEEPING	204,412	3,277	0	36,512	458	9.00
10.00	01000	DIETARY	280,670	8,594	231	41,331	2,027	10.00
11.00	01100	CAFETERIA	0	3,495	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	159,888	3,625	0	32,456	719	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	37,242	3,065	0	3,482	2,354	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	242,465	7,214	579	44,695	1,373	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	182	589	0	33	0	16.01
17.00	01700	SOCIAL SERVICE	69,029	902	0	14,403	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,351,077	54,479	29,378	254,707	10,660	30.00
44.00	04400	SKILLED NURSING FACILITY	523,460	40,292	0	104,366	3,793	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	153,185	12,348	57,356	7,683	1,439	50.00
53.00	05300	ANESTHESIOLOGY	43,711	0	0	0	131	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	303,308	8,211	96,625	48,944	2,027	54.00
60.00	06000	LABORATORY	602,812	8,405	5,377	68,848	3,074	60.00
64.00	06400	INTRAVENOUS THERAPY	46,738	0	0	3,598	0	64.00
65.00	06500	RESPIRATORY THERAPY	28,366	0	0	109	0	65.00
66.00	06600	PHYSICAL THERAPY	245,188	8,541	0	52,943	2,550	66.00
67.00	06700	OCCUPATIONAL THERAPY	186,947	2,918	0	40,024	0	67.00
68.00	06800	SPEECH PATHOLOGY	13,026	0	0	2,728	0	68.00
69.00	06900	ELECTROCARDIOLOGY	631	0	1,545	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	30,282	0	0	0	2,747	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,076	0	0	0	131	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	374,314	2,853	0	26,898	654	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,749,160	30,243	600	84,931	13,341	88.00
91.00	09100	EMERGENCY	1,427,730	6,277	2,937	84,650	10,594	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	24,085	1,809	0	2,969	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	106,687	16,621	30,038	14,660	4,447	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,182,103	329,033	296,865	1,176,974	71,413	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	6,788	0	0	170	0	194.00
194.01	07951	RENTAL SPACE	0	171	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,188,891	329,204	296,865	1,177,144	71,413	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 10/27/2015 8:26 am

		Cost Center Description	PERSONNEL	HOSPITAL BILLING	NURSING HOME BILLING	Subtotal	OTHER ADMINISTRATIVE AND GENERAL	
			5.02	5.03	5.04	5A.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL	143,174					5.02
5.03	00580	HOSPITAL BILLING	6,351	416,964				5.03
5.04	00592	NURSING HOME BILLING	10	0	1,205			5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	9,323	0	0	1,264,336	1,264,336	5.05
7.00	00700	OPERATION OF PLANT	3,694	0	0	643,076	74,425	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	42,801	4,953	8.00
9.00	00900	HOUSEKEEPING	3,960	0	0	248,619	28,773	9.00
10.00	01000	DIETARY	4,483	0	0	337,336	39,041	10.00
11.00	01100	CAFETERIA	0	0	0	3,495	404	11.00
13.00	01300	NURSING ADMINISTRATION	3,520	0	0	200,208	23,171	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	378	0	0	46,521	5,384	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,848	0	0	301,174	34,856	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	4	0	0	808	94	16.01
17.00	01700	SOCIAL SERVICE	1,562	0	0	85,896	9,941	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	27,626	43,198	0	1,771,125	204,978	30.00
44.00	04400	SKILLED NURSING FACILITY	11,320	0	1,205	684,436	79,212	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	833	17,141	0	249,985	28,932	50.00
53.00	05300	ANESTHESIOLOGY	0	1,921	0	45,763	5,296	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,309	50,578	0	515,002	59,603	54.00
60.00	06000	LABORATORY	7,468	65,889	0	761,873	88,174	60.00
64.00	06400	INTRAVENOUS THERAPY	390	20,903	0	71,629	8,290	64.00
65.00	06500	RESPIRATORY THERAPY	12	9,418	0	37,905	4,387	65.00
66.00	06600	PHYSICAL THERAPY	5,742	31,098	0	346,062	40,051	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,341	19,452	0	253,682	29,359	67.00
68.00	06800	SPEECH PATHOLOGY	296	1,321	0	17,371	2,010	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,892	0	5,068	587	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,717	0	39,746	4,600	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	293	0	3,500	405	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,917	42,638	0	450,274	52,112	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	27,676	57,603	0	1,963,554	227,251	88.00
91.00	09100	EMERGENCY	9,181	25,686	0	1,567,055	181,360	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	WOUND CARE	322	1,744	0	30,929	3,580	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,590	18,472	0	192,515	22,280	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	143,156	416,964	1,205	12,181,744	1,263,509	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	18	0	0	6,976	807	194.00
194.01	07951	RENTAL SPACE	0	0	0	171	20	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	143,174	416,964	1,205	12,188,891	1,264,336	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 10/27/2015 8:26 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	HOSPITAL BILLING						5.03
5.04	00592	NURSING HOME BILLING						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	717,501					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	24,304	72,058				8.00
9.00	00900	HOUSEKEEPING	10,145	0	287,537			9.00
10.00	01000	DIETARY	26,602	0	760	403,739		10.00
11.00	01100	CAFETERIA	10,820	0	0	123,585	138,304	11.00
13.00	01300	NURSING ADMINISTRATION	11,221	0	1,723	0	2,578	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,488	0	4,817	0	563	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	22,333	0	5,160	0	8,015	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	1,825	0	926	0	0	16.01
17.00	01700	SOCIAL SERVICE	2,792	0	1,417	0	1,482	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	168,645	32,235	84,135	108,562	36,225	30.00
44.00	04400	SKILLED NURSING FACILITY	124,729	20,953	65,562	169,690	21,660	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,225	1,057	16,101	0	1,067	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,417	1,793	11,423	0	6,563	54.00
60.00	06000	LABORATORY	26,019	72	13,211	0	9,749	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	222	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	15	65.00
66.00	06600	PHYSICAL THERAPY	26,438	1,766	13,424	0	5,245	66.00
67.00	06700	OCCUPATIONAL THERAPY	9,032	0	4,586	0	2,993	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	163	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	44	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,831	0	3,761	0	2,637	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	93,620	3,857	47,543	0	19,690	88.00
91.00	09100	EMERGENCY	19,432	9,191	9,875	0	5,348	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	5,601	0	2,844	0	326	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	51,453	1,134	0	0	13,719	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	716,972	72,058	287,268	401,837	138,304	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	529	0	269	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	1,902	0	194.02
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)	717,501	72,058	287,537	403,739	138,304	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 10/27/2015 8:26 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NURSING HOME MEDICAL RECORDS & LIBR	SOCIAL SERVICE	
			13.00	14.00	16.00	16.01	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	HOSPITAL BILLING						5.03
5.04	00592	NURSING HOME BILLING						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	238,901					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	66,773				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	371,538			16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	0	0	3,653		16.01
17.00	01700	SOCIAL SERVICE	5,115	0	0	0	106,643	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	125,050	0	36,733	0	97,350	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	3,653	9,293	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,674	37,811	17,820	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	1,633	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	43,008	0	0	54.00
60.00	06000	LABORATORY	0	0	56,033	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	17,775	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	44	0	8,009	0	0	65.00
66.00	06600	PHYSICAL THERAPY	18,125	0	26,443	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	10,310	0	16,541	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	585	0	1,123	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	3,310	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	5,712	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	249	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,081	0	36,256	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	28,023	52,889	0	0	88.00
91.00	09100	EMERGENCY	18,455	939	30,814	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	1,124	0	1,483	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	47,338	0	15,707	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	238,901	66,773	371,538	3,653	106,643	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	238,901	66,773	371,538	3,653	106,643	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 10/27/2015 8:26 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	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING					5.01
5.02	00591	PERSONNEL					5.02
5.03	00580	HOSPITAL BILLING					5.03
5.04	00592	NURSING HOME BILLING					5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL					5.05
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
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR					16.01
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	2,665,038	-24,979	2,640,059		30.00
44.00	04400	SKILLED NURSING FACILITY	1,179,188	0	1,179,188		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	394,672	0	394,672		50.00
53.00	05300	ANESTHESIOLOGY	52,692	0	52,692		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	662,809	0	662,809		54.00
60.00	06000	LABORATORY	955,131	0	955,131		60.00
64.00	06400	INTRAVENOUS THERAPY	97,916	24,979	122,895		64.00
65.00	06500	RESPIRATORY THERAPY	50,360	0	50,360		65.00
66.00	06600	PHYSICAL THERAPY	477,554	0	477,554		66.00
67.00	06700	OCCUPATIONAL THERAPY	326,503	0	326,503		67.00
68.00	06800	SPEECH PATHOLOGY	21,252	0	21,252		68.00
69.00	06900	ELECTROCARDIOLOGY	9,009	0	9,009		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,058	0	50,058		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,154	0	4,154		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	562,952	0	562,952		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	2,436,427	0	2,436,427		88.00
91.00	09100	EMERGENCY	1,842,469	0	1,842,469		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
93.00	04950	WOUND CARE	45,887	0	45,887		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	344,146	0	344,146		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,178,217	0	12,178,217		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
194.00	07950	OPTH CLINIC	7,783	0	7,783		194.00
194.01	07951	RENTAL SPACE	989	0	989		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	1,902	0	1,902		194.02
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)	12,188,891	0	12,188,891		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 10/27/2015 8:26 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.01	00560	PURCHASING	0	9,973	0	9,973	0	5.01
5.02	00591	PERSONNEL	0	2,982	0	2,982	0	5.02
5.03	00580	HOSPITAL BILLING	0	5,476	0	5,476	0	5.03
5.04	00592	NURSING HOME BILLING	0	554	0	554	0	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	0	16,786	68,318	85,104	0	5.05
7.00	00700	OPERATION OF PLANT	0	61,653	3,881	65,534	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	7,851	0	7,851	0	8.00
9.00	00900	HOUSEKEEPING	0	3,277	0	3,277	0	9.00
10.00	01000	DIETARY	0	8,594	231	8,825	0	10.00
11.00	01100	CAFETERIA	0	3,495	0	3,495	0	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,625	0	3,625	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,065	0	3,065	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	7,214	579	7,793	0	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	589	0	589	0	16.01
17.00	01700	SOCIAL SERVICE	0	902	0	902	0	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	54,479	29,378	83,857	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	40,292	0	40,292	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	12,348	57,356	69,704	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,211	96,625	104,836	0	54.00
60.00	06000	LABORATORY	0	8,405	5,377	13,782	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,541	0	8,541	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,918	0	2,918	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	1,545	1,545	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,853	0	2,853	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	30,243	600	30,843	0	88.00
91.00	09100	EMERGENCY	0	6,277	2,937	9,214	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
93.00	04950	WOUND CARE	0	1,809	0	1,809	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	16,621	30,038	46,659	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	329,033	296,865	625,898	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	171	0	171	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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	329,204	296,865	626,069	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 10/27/2015 8:26 am

		Cost Center Description	PURCHASING	PERSONNEL	HOSPITAL BILLING	NURSING HOME BILLING	OTHER ADMINISTRATIVE AND GENERAL	
			5.01	5.02	5.03	5.04	5.05	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING	9,973					5.01
5.02	00591	PERSONNEL	27	3,009				5.02
5.03	00580	HOSPITAL BILLING	219	133	5,828			5.03
5.04	00592	NURSING HOME BILLING	0	0	0	554		5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	740	196	0	0	86,040	5.05
7.00	00700	OPERATION OF PLANT	237	78	0	0	5,065	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	18	0	0	0	337	8.00
9.00	00900	HOUSEKEEPING	64	83	0	0	1,958	9.00
10.00	01000	DIETARY	283	94	0	0	2,657	10.00
11.00	01100	CAFETERIA	0	0	0	0	28	11.00
13.00	01300	NURSING ADMINISTRATION	100	74	0	0	1,577	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	329	8	0	0	366	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	192	102	0	0	2,372	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	0	0	0	6	16.01
17.00	01700	SOCIAL SERVICE	0	33	0	0	677	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,489	580	604	0	13,949	30.00
44.00	04400	SKILLED NURSING FACILITY	530	238	0	554	5,391	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	201	17	240	0	1,969	50.00
53.00	05300	ANESTHESIOLOGY	18	0	27	0	360	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	283	111	707	0	4,056	54.00
60.00	06000	LABORATORY	429	157	921	0	6,001	60.00
64.00	06400	INTRAVENOUS THERAPY	0	8	292	0	564	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	132	0	299	65.00
66.00	06600	PHYSICAL THERAPY	356	121	435	0	2,726	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	91	272	0	1,998	67.00
68.00	06800	SPEECH PATHOLOGY	0	6	18	0	137	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	40	0	40	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	384	0	94	0	313	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18	0	4	0	28	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	91	61	596	0	3,546	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	1,864	585	805	0	15,462	88.00
91.00	09100	EMERGENCY	1,480	193	359	0	12,342	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	0	7	24	0	244	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	621	33	258	0	1,516	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,973	3,009	5,828	554	85,984	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	55	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	1	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	9,973	3,009	5,828	554	86,040	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 10/27/2015 8:26 am

		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	HOSPITAL BILLING						5.03
5.04	00592	NURSING HOME BILLING						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT	70,914					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,402	10,608				8.00
9.00	00900	HOUSEKEEPING	1,003	0	6,385			9.00
10.00	01000	DIETARY	2,629	0	17	14,505		10.00
11.00	01100	CAFETERIA	1,069	0	0	4,440	9,032	11.00
13.00	01300	NURSING ADMINISTRATION	1,109	0	38	0	168	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	938	0	107	0	37	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,207	0	115	0	523	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	180	0	21	0	0	16.01
17.00	01700	SOCIAL SERVICE	276	0	31	0	97	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	16,667	4,744	1,867	3,900	2,364	30.00
44.00	04400	SKILLED NURSING FACILITY	12,328	3,085	1,456	6,097	1,415	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,778	156	358	0	70	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,512	264	254	0	429	54.00
60.00	06000	LABORATORY	2,572	11	293	0	637	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	15	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	1	65.00
66.00	06600	PHYSICAL THERAPY	2,613	260	298	0	343	66.00
67.00	06700	OCCUPATIONAL THERAPY	893	0	102	0	195	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	11	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	3	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	873	0	84	0	172	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,253	568	1,056	0	1,286	88.00
91.00	09100	EMERGENCY	1,921	1,353	219	0	349	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	554	0	63	0	21	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	5,085	167	0	0	896	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	70,862	10,608	6,379	14,437	9,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	52	0	6	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	68	0	194.02
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)	70,914	10,608	6,385	14,505	9,032	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 10/27/2015 8:26 am

		Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	NURSING HOME MEDICAL RECORDS & LIBR	SOCIAL SERVICE	
			13.00	14.00	16.00	16.01	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	HOSPITAL BILLING						5.03
5.04	00592	NURSING HOME BILLING						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
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	6,691					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,850				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	13,304			16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	0	0	796		16.01
17.00	01700	SOCIAL SERVICE	143	0	0	0	2,159	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,503	0	1,316	0	1,971	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	796	188	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	103	2,747	638	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	58	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	1,540	0	0	54.00
60.00	06000	LABORATORY	0	0	2,003	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	637	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1	0	287	0	0	65.00
66.00	06600	PHYSICAL THERAPY	508	0	947	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	289	0	592	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	16	0	40	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	119	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	205	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	9	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	254	0	1,299	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	2,035	1,894	0	0	88.00
91.00	09100	EMERGENCY	517	68	1,104	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	31	0	53	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,326	0	563	0	0	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,691	4,850	13,304	796	2,159	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	6,691	4,850	13,304	796	2,159	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 10/27/2015 8:26 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	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00560	PURCHASING					5.01
5.02	00591	PERSONNEL					5.02
5.03	00580	HOSPITAL BILLING					5.03
5.04	00592	NURSING HOME BILLING					5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL					5.05
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
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR					16.01
17.00	01700	SOCIAL SERVICE					17.00
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	136,811	0	136,811		30.00
44.00	04400	SKILLED NURSING FACILITY	72,370	0	72,370		44.00
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	79,981	0	79,981		50.00
53.00	05300	ANESTHESIOLOGY	463	0	463		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,992	0	114,992		54.00
60.00	06000	LABORATORY	26,806	0	26,806		60.00
64.00	06400	INTRAVENOUS THERAPY	1,516	0	1,516		64.00
65.00	06500	RESPIRATORY THERAPY	720	0	720		65.00
66.00	06600	PHYSICAL THERAPY	17,148	0	17,148		66.00
67.00	06700	OCCUPATIONAL THERAPY	7,350	0	7,350		67.00
68.00	06800	SPEECH PATHOLOGY	228	0	228		68.00
69.00	06900	ELECTROCARDIOLOGY	1,747	0	1,747		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	996	0	996		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	59	0	59		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,829	0	9,829		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	65,651	0	65,651		88.00
91.00	09100	EMERGENCY	29,119	0	29,119		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
93.00	04950	WOUND CARE	2,806	0	2,806		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	57,124	0	57,124		95.00
		SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	625,716	0	625,716		118.00
		NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
194.00	07950	OPTH CLINIC	55	0	55		194.00
194.01	07951	RENTAL SPACE	230	0	230		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	68	0	68		194.02
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)	626,069	0	626,069		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 10/27/2015 8:26 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	PURCHASING (PURCHASE ORDERS)	PERSONNEL (GROSS SALARIES)	
			1.00	2.00	4.00	5.01	5.02	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	55,853					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		281,891				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	5,619,841			4.00
5.01	00560	PURCHASING	1,692	0	47,567	1,092		5.01
5.02	00591	PERSONNEL	506	0	100,491	3	6,301,819	5.02
5.03	00580	HOSPITAL BILLING	929	0	267,414	24	279,542	5.03
5.04	00592	NURSING HOME BILLING	94	0	426	0	426	5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	2,848	64,872	405,010	81	410,350	5.05
7.00	00700	OPERATION OF PLANT	10,460	3,685	162,587	26	162,587	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,332	0	0	2	0	8.00
9.00	00900	HOUSEKEEPING	556	0	174,314	7	174,314	9.00
10.00	01000	DIETARY	1,458	219	197,318	31	197,318	10.00
11.00	01100	CAFETERIA	593	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	615	0	154,949	11	154,949	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	520	0	16,622	36	16,622	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,224	550	213,382	21	213,382	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	100	0	158	0	158	16.01
17.00	01700	SOCIAL SERVICE	153	0	68,763	0	68,763	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,243	27,896	1,215,995	163	1,215,995	30.00
44.00	04400	SKILLED NURSING FACILITY	6,836	0	498,257	58	498,257	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,095	54,463	36,679	22	36,679	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	2	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,393	91,751	233,663	31	233,663	54.00
60.00	06000	LABORATORY	1,426	5,106	328,690	47	328,690	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	17,177	0	17,177	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	519	0	519	65.00
66.00	06600	PHYSICAL THERAPY	1,449	0	252,759	39	252,759	66.00
67.00	06700	OCCUPATIONAL THERAPY	495	0	191,082	0	191,082	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	13,026	0	13,026	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,467	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	42	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	484	0	128,416	10	128,416	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	5,131	570	405,470	204	1,218,038	88.00
91.00	09100	EMERGENCY	1,065	2,789	404,132	162	404,132	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	307	0	14,175	0	14,175	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,820	28,523	69,987	68	69,987	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,824	281,891	5,619,028	1,092	6,301,006	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	813	0	813	194.00
194.01	07951	RENTAL SPACE	29	0	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	329,204	296,865	1,177,144	71,413	143,174	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.894115	1.053120	0.209462	65.396520	0.022719	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			0	9,973	3,009	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000000	9.132784	0.000477	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 10/27/2015 8:26 am

		Cost Center Description	HOSPITAL BILLING (NON-NURSIN G HOME CH)	NURSING HOME BILLING (NURSING HO ME CHARGE)	Reconciliatio n	OTHER ADMINISTRATIV E AND GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	7.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	HOSPITAL BILLING	14,530,372					5.03
5.04	00592	NURSING HOME BILLING	0	809,300				5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL	0	0	-1,264,336	10,924,555		5.05
7.00	00700	OPERATION OF PLANT	0	0	0	643,076	39,324	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	42,801	1,332	8.00
9.00	00900	HOUSEKEEPING	0	0	0	248,619	556	9.00
10.00	01000	DIETARY	0	0	0	337,336	1,458	10.00
11.00	01100	CAFETERIA	0	0	0	3,495	593	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	200,208	615	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	46,521	520	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	301,174	1,224	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	0	0	808	100	16.01
17.00	01700	SOCIAL SERVICE	0	0	0	85,896	153	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,505,382	0	0	1,771,125	9,243	30.00
44.00	04400	SKILLED NURSING FACILITY	0	809,300	0	684,436	6,836	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	597,319	0	0	249,985	2,095	50.00
53.00	05300	ANESTHESIOLOGY	66,932	0	0	45,763	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,762,541	0	0	515,002	1,393	54.00
60.00	06000	LABORATORY	2,296,112	0	0	761,873	1,426	60.00
64.00	06400	INTRAVENOUS THERAPY	728,440	0	0	71,629	0	64.00
65.00	06500	RESPIRATORY THERAPY	328,209	0	0	37,905	0	65.00
66.00	06600	PHYSICAL THERAPY	1,083,705	0	0	346,062	1,449	66.00
67.00	06700	OCCUPATIONAL THERAPY	677,879	0	0	253,682	495	67.00
68.00	06800	SPEECH PATHOLOGY	46,020	0	0	17,371	0	68.00
69.00	06900	ELECTROCARDIOLOGY	100,792	0	0	5,068	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	234,075	0	0	39,746	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,216	0	0	3,500	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,485,848	0	0	450,274	484	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,007,342	0	0	1,963,554	5,131	88.00
91.00	09100	EMERGENCY	895,100	0	0	1,567,055	1,065	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	60,759	0	0	30,929	307	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	643,701	0	0	192,515	2,820	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	14,530,372	809,300	-1,264,336	10,917,408	39,295	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	6,976	0	194.00
194.01	07951	RENTAL SPACE	0	0	0	171	29	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.02
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)	416,964	1,205		1,264,336	717,501	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.028696	0.001489		0.115733	18.245880	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	5,828	554		86,040	70,914	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000401	0.000685		0.007876	1.803326	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 10/27/2015 8:26 am

		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (FTE'S)	NURSING ADMINISTRATION (HOURS OF SERVICE)	
			8.00	9.00	10.00	11.00	13.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	HOSPITAL BILLING						5.03
5.04	00592	NURSING HOME BILLING						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE	15,954					8.00
9.00	00900	HOUSEKEEPING	0	31,038				9.00
10.00	01000	DIETARY	0	82	33,110			10.00
11.00	01100	CAFETERIA	0	0	10,135	9,335		11.00
13.00	01300	NURSING ADMINISTRATION	0	186	0	174	97,155	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	520	0	38	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	557	0	541	0	16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	100	0	0	0	16.01
17.00	01700	SOCIAL SERVICE	0	153	0	100	2,080	17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	7,137	9,082	8,903	2,445	50,855	30.00
44.00	04400	SKILLED NURSING FACILITY	4,639	7,077	13,916	1,462	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	234	1,738	0	72	1,494	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	397	1,233	0	443	0	54.00
60.00	06000	LABORATORY	16	1,426	0	658	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	15	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1	18	65.00
66.00	06600	PHYSICAL THERAPY	391	1,449	0	354	7,371	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	495	0	202	4,193	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	11	238	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	3	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	406	0	178	3,693	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	854	5,132	0	1,329	0	88.00
91.00	09100	EMERGENCY	2,035	1,066	0	361	7,505	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	0	307	0	22	457	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	251	0	0	926	19,251	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,954	31,009	32,954	9,335	97,155	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
194.00	07950	OPTH CLINIC	0	0	0	0	0	194.00
194.01	07951	RENTAL SPACE	0	29	0	0	0	194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	156	0	0	194.02
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)	72,058	287,537	403,739	138,304	238,901	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.516610	9.264031	12.193869	14.815640	2.458968	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	10,608	6,385	14,505	9,032	6,691	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.664912	0.205716	0.438085	0.967542	0.068869	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 10/27/2015 8:26 am

		Cost Center Description	CENTRAL SERVICES & SUPPLY (# OF LOADS)	MEDICAL RECORDS & LIBRARY (NON-NURSIN G HOME CH)	NURSING HOME MEDICAL RECORDS & LIBR (NURSING HO ME CHARGE)	SOCIAL SERVICE (TIME SPENT)		
			14.00	16.00	16.01	17.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00560	PURCHASING						5.01
5.02	00591	PERSONNEL						5.02
5.03	00580	HOSPITAL BILLING						5.03
5.04	00592	NURSING HOME BILLING						5.04
5.05	00590	OTHER ADMINISTRATIVE AND GENERAL						5.05
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
14.00	01400	CENTRAL SERVICES & SUPPLY	498					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	15,226,086				16.00
16.01	01601	NURSING HOME MEDICAL RECORDS & LIBR	0	0	809,300			16.01
17.00	01700	SOCIAL SERVICE	0	0	0	482		17.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	1,505,382	0	440		30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	809,300	42		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	282	730,317	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	66,932	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,762,541	0	0		54.00
60.00	06000	LABORATORY	0	2,296,112	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	728,440	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	328,209	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	1,083,705	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	677,879	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	46,020	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	135,654	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	234,075	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,216	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,485,848	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	209	2,167,478	0	0		88.00
91.00	09100	EMERGENCY	7	1,262,818	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950	WOUND CARE	0	60,759	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	643,701	0	0		95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	498	15,226,086	809,300	482		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
194.00	07950	OPTH CLINIC	0	0	0	0		194.00
194.01	07951	RENTAL SPACE	0	0	0	0		194.01
194.02	07952	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0		194.02
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)	66,773	371,538	3,653	106,643		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	134.082329	0.024401	0.004514	221.251037		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	4,850	13,304	796	2,159		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	9.738956	0.000874	0.000984	4.479253		205.00

POST STEPDOWN ADJUSTMENTS | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-2 | Date/Time Prepared: 10/27/2015 8:26 am

		Description	Worksheet Part	Worksheet Line No.	Amount	
		1.00	2.00	3.00	4.00	
1.00		ADJ FOR EPO COSTS IN RENAL DIALYSIS	1	74.00	0	1.00
2.00		ADJ FOR EPO COSTS IN HOME PROGRAM	1	94.00	0	2.00
3.00		ADJ FOR ARANESP COSTS IN RENAL DIALYSIS	1	74.00	0	3.00
4.00		ADJ FOR ARANESP COSTS IN HOME PROGRAM	1	94.00	0	4.00
5.00		ADJ FOR ESA COSTS IN RENAL DIALYSIS	1	74.00	0	5.00
6.00		ADJ FOR ESA COSTS IN HOME PROGRAM	1	94.00	0	6.00
7.00		IV THERAPY	1	30.00	-24,979	7.00
8.00		IV THERAPY	1	64.00	24,979	8.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 10/27/2015 8:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,640,059		2,640,059	0	2,640,059	30.00
44.00	04400	SKILLED NURSING FACILITY	1,179,188		1,179,188	0	1,179,188	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	394,672		394,672	0	394,672	50.00
53.00	05300	ANESTHESIOLOGY	52,692		52,692	0	52,692	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	662,809		662,809	0	662,809	54.00
60.00	06000	LABORATORY	955,131		955,131	0	955,131	60.00
64.00	06400	INTRAVENOUS THERAPY	122,895		122,895	0	122,895	64.00
65.00	06500	RESPIRATORY THERAPY	50,360	0	50,360	0	50,360	65.00
66.00	06600	PHYSICAL THERAPY	477,554	0	477,554	0	477,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	326,503	0	326,503	0	326,503	67.00
68.00	06800	SPEECH PATHOLOGY	21,252	0	21,252	0	21,252	68.00
69.00	06900	ELECTROCARDIOLOGY	9,009		9,009	0	9,009	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,058		50,058	0	50,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,154		4,154	0	4,154	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	562,952		562,952	0	562,952	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,436,427		2,436,427	0	2,436,427	88.00
91.00	09100	EMERGENCY	1,842,469		1,842,469	0	1,842,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	79,328		79,328		79,328	92.00
93.00	04950	WOUND CARE	45,887		45,887	0	45,887	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	344,146		344,146	0	344,146	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,257,545	0	12,257,545	0	12,257,545	200.00
201.00		Less Observation Beds	79,328		79,328		79,328	201.00
202.00		Total (see instructions)	12,178,217	0	12,178,217	0	12,178,217	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 10/27/2015 8:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,322,084		1,322,084			30.00
44.00	04400	SKILLED NURSING FACILITY	809,300		809,300			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,000	580,978	584,978	0.674678	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	66,348	66,348	0.794176	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,400	1,684,350	1,739,750	0.380979	0.000000	54.00
60.00	06000	LABORATORY	189,301	2,072,651	2,261,952	0.422260	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	152,194	565,169	717,363	0.171315	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	249,770	77,324	327,094	0.153962	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	550,716	521,793	1,072,509	0.445268	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	443,087	223,478	666,565	0.489829	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,212	29,808	46,020	0.461799	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,786	96,812	99,598	0.090454	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	162,311	70,615	232,926	0.214909	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,216	10,216	0.406617	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	974,184	507,980	1,482,164	0.379818	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	113,825	1,868,803	1,982,628			88.00
91.00	09100	EMERGENCY	3,000	886,108	889,108	2.072267	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	180,660	180,660	0.439101	0.000000	92.00
93.00	04950	WOUND CARE	1,400	59,359	60,759	0.755230	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	641,215	641,215	0.536709	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,049,570	10,143,667	15,193,237			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,049,570	10,143,667	15,193,237			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 10/27/2015 8:26 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
44.00	04400	SKILLED NURSING FACILITY			44.00
		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
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950	WOUND CARE	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 10/27/2015 8:26 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,640,059		2,640,059	0	2,640,059	30.00
44.00	04400	SKILLED NURSING FACILITY	1,179,188		1,179,188	0	1,179,188	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	394,672		394,672	0	394,672	50.00
53.00	05300	ANESTHESIOLOGY	52,692		52,692	0	52,692	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	662,809		662,809	0	662,809	54.00
60.00	06000	LABORATORY	955,131		955,131	0	955,131	60.00
64.00	06400	INTRAVENOUS THERAPY	122,895		122,895	0	122,895	64.00
65.00	06500	RESPIRATORY THERAPY	50,360	0	50,360	0	50,360	65.00
66.00	06600	PHYSICAL THERAPY	477,554	0	477,554	0	477,554	66.00
67.00	06700	OCCUPATIONAL THERAPY	326,503	0	326,503	0	326,503	67.00
68.00	06800	SPEECH PATHOLOGY	21,252	0	21,252	0	21,252	68.00
69.00	06900	ELECTROCARDIOLOGY	9,009		9,009	0	9,009	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	50,058		50,058	0	50,058	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,154		4,154	0	4,154	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	562,952		562,952	0	562,952	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,436,427		2,436,427	0	2,436,427	88.00
91.00	09100	EMERGENCY	1,842,469		1,842,469	0	1,842,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	79,328		79,328		79,328	92.00
93.00	04950	WOUND CARE	45,887		45,887	0	45,887	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	344,146		344,146	0	344,146	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	12,257,545	0	12,257,545	0	12,257,545	200.00
201.00		Less Observation Beds	79,328		79,328		79,328	201.00
202.00		Total (see instructions)	12,178,217	0	12,178,217	0	12,178,217	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 10/27/2015 8:26 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,322,084		1,322,084			30.00
44.00	04400	SKILLED NURSING FACILITY	809,300		809,300			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,000	580,978	584,978	0.674678	0.000000	50.00
53.00	05300	ANESTHESIOLOGY	0	66,348	66,348	0.794176	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	55,400	1,684,350	1,739,750	0.380979	0.000000	54.00
60.00	06000	LABORATORY	189,301	2,072,651	2,261,952	0.422260	0.000000	60.00
64.00	06400	INTRAVENOUS THERAPY	152,194	565,169	717,363	0.171315	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	249,770	77,324	327,094	0.153962	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	550,716	521,793	1,072,509	0.445268	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	443,087	223,478	666,565	0.489829	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	16,212	29,808	46,020	0.461799	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	2,786	96,812	99,598	0.090454	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	162,311	70,615	232,926	0.214909	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,216	10,216	0.406617	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	974,184	507,980	1,482,164	0.379818	0.000000	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	113,825	1,868,803	1,982,628	1.228888	0.000000	88.00
91.00	09100	EMERGENCY	3,000	886,108	889,108	2.072267	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	180,660	180,660	0.439101	0.000000	92.00
93.00	04950	WOUND CARE	1,400	59,359	60,759	0.755230	0.000000	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	641,215	641,215	0.536709	0.000000	95.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	5,049,570	10,143,667	15,193,237			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	5,049,570	10,143,667	15,193,237			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 10/27/2015 8:26 am

Title XIX | Hospital | Cost

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
44.00	04400	SKILLED NURSING FACILITY			44.00
		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
64.00	06400	INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
93.00	04950	WOUND CARE	0.000000		93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
		SPECIAL PURPOSE COST CENTERS			
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II Date/Time Prepared: 10/27/2015 8:26 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	79,981	584,978	0.136725	0	0	50.00
53.00	05300	ANESTHESIOLOGY	463	66,348	0.006978	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	114,992	1,739,750	0.066097	9,081	600	54.00
60.00	06000	LABORATORY	26,806	2,261,952	0.011851	36,760	436	60.00
64.00	06400	INTRAVENOUS THERAPY	1,516	717,363	0.002113	2,161	5	64.00
65.00	06500	RESPIRATORY THERAPY	720	327,094	0.002201	32,311	71	65.00
66.00	06600	PHYSICAL THERAPY	17,148	1,072,509	0.015989	1,002	16	66.00
67.00	06700	OCCUPATIONAL THERAPY	7,350	666,565	0.011027	253	3	67.00
68.00	06800	SPEECH PATHOLOGY	228	46,020	0.004954	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,747	99,598	0.017541	796	14	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	996	232,926	0.004276	29,309	125	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	59	10,216	0.005775	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,829	1,482,164	0.006632	107,552	713	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	65,651	1,982,628	0.033113	0	0	88.00
91.00	09100	EMERGENCY	29,119	889,108	0.032751	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	39,603	180,660	0.219213	0	0	92.00
93.00	04950	WOUND CARE	2,806	60,759	0.046182	57	3	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	399,014	12,420,638		219,282	1,986	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 10/27/2015 8:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04950	WOUND CARE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 10/27/2015 8:26 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	584,978	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	66,348	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,739,750	0.000000	0.000000	9,081	54.00
60.00	06000	LABORATORY	0	2,261,952	0.000000	0.000000	36,760	60.00
64.00	06400	INTRAVENOUS THERAPY	0	717,363	0.000000	0.000000	2,161	64.00
65.00	06500	RESPIRATORY THERAPY	0	327,094	0.000000	0.000000	32,311	65.00
66.00	06600	PHYSICAL THERAPY	0	1,072,509	0.000000	0.000000	1,002	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	666,565	0.000000	0.000000	253	67.00
68.00	06800	SPEECH PATHOLOGY	0	46,020	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	99,598	0.000000	0.000000	796	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	232,926	0.000000	0.000000	29,309	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,216	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,482,164	0.000000	0.000000	107,552	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,982,628	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	889,108	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	180,660	0.000000	0.000000	0	92.00
93.00	04950	WOUND CARE	0	60,759	0.000000	0.000000	57	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	12,420,638			219,282	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 10/27/2015 8:26 am

Title XVIII | Hospital | Cost

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04950	WOUND CARE	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 10/27/2015 8:26 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	0.674678	0	176,163	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.794176	0	21,923	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.380979	0	409,035	0	0	54.00
60.00	06000	LABORATORY	0.422260	0	604,813	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.171315	0	188,766	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.153962	0	35,832	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.445268	0	242,631	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.489829	0	73,711	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.461799	0	10,071	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.090454	0	40,393	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.214909	0	41,918	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406617	0	3,140	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379818	0	158,861	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	2.072267	0	231,786	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.439101	0	57,932	0	0	92.00
93.00	04950	WOUND CARE	0.755230	0	22,394	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.536709		0			95.00
200.00		Subtotal (see instructions)		0	2,319,369	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	2,319,369	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 10/27/2015 8:26 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	118,853	0	50.00
53.00	05300	ANESTHESIOLOGY	17,411	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	155,834	0	54.00
60.00	06000	LABORATORY	255,388	0	60.00
64.00	06400	INTRAVENOUS THERAPY	32,338	0	64.00
65.00	06500	RESPIRATORY THERAPY	5,517	0	65.00
66.00	06600	PHYSICAL THERAPY	108,036	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	36,106	0	67.00
68.00	06800	SPEECH PATHOLOGY	4,651	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,654	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,009	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,277	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	60,338	0	73.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
91.00	09100	EMERGENCY	480,322	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	25,438	0	92.00
93.00	04950	WOUND CARE	16,913	0	93.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	1,331,085	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	1,331,085	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 141329 | Component CCN: 14Z329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 10/27/2015 8:26 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	0.674678	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.794176	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.380979	0	0	0	0	54.00
60.00	06000	LABORATORY	0.422260	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0.171315	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.153962	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.445268	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.489829	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.461799	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.090454	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.214909	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406617	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379818	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
91.00	09100	EMERGENCY	2.072267	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.439101	0	0	0	0	92.00
93.00	04950	WOUND CARE	0.755230	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.536709		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: 141329 | Component CCN: 14Z329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 10/27/2015 8:26 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
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04950	WOUND CARE	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Component CCN: 145274 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 10/27/2015 8:26 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04950	WOUND CARE	0	0	0	0	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Component CCN: 145274 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 10/27/2015 8:26 am

Title XVIII | Skilled Nursing Facility | PPS

		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	584,978	0.000000	0.000000	0	50.00
53.00	05300	ANESTHESIOLOGY	0	66,348	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,739,750	0.000000	0.000000	0	54.00
60.00	06000	LABORATORY	0	2,261,952	0.000000	0.000000	0	60.00
64.00	06400	INTRAVENOUS THERAPY	0	717,363	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	327,094	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	1,072,509	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	666,565	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	46,020	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	99,598	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	232,926	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	10,216	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,482,164	0.000000	0.000000	0	73.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	1,982,628	0.000000	0.000000	0	88.00
91.00	09100	EMERGENCY	0	889,108	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	180,660	0.000000	0.000000	0	92.00
93.00	04950	WOUND CARE	0	60,759	0.000000	0.000000	0	93.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50-199)	0	12,420,638			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 10/27/2015 8:26 am

Component CCN: 145274 | Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	0		50.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
60.00	06000	LABORATORY	0	0	0		60.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
93.00	04950	WOUND CARE	0	0	0		93.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
200.00		Total (lines 50-199)	0	0	0		200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 10/27/2015 8:26 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)	3,053	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	266	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)	189	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,138	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)	1,085	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	282	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)	282	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	118	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)	962	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)	961	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	134.54	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	134.54	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,640,059	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)	37,940	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)	37,940	25.00
26.00	Total swing-bed cost (see instructions)	2,366,015	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	274,044	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)	274,044	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)	1,030.20	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	121,564	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)	121,564	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 10/27/2015 8:26 am

Title XVIII | Hospital | Cost

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	72,161	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	193,725	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)	991,052	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	990,022	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	1,981,074	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	77	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,030.24	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	79,328	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 10/27/2015 8:26 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	136,811	274,044	0.499230	79,328	39,603	90.00
91.00	Nursing School cost	0	274,044	0.000000	79,328	0	91.00
92.00	Allied health cost	0	274,044	0.000000	79,328	0	92.00
93.00	All other Medical Education	0	274,044	0.000000	79,328	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 141329 Component CCN: 145274	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 10/27/2015 8:26 am
	Title XVIII	Skilled Nursing Facility	PPS

	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)	9,369	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,369	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)	9,369	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	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	0	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)	0	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	1,179,188	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)	0	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)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,179,188	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)	1,179,188	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1

Component CCN: 145274 | Date/Time Prepared: 10/27/2015 8:26 am

Title XVIII | Skilled Nursing Facility | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		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)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		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		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		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)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		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)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		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)		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)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)	1,179,188	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	125.86	71.00
72.00	Program routine service cost (line 9 x line 71)	0	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	0	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	0	83.00
84.00	Program inpatient ancillary services (see instructions)	0	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	0	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1

Component CCN: 145274 | Date/Time Prepared: 10/27/2015 8:26 am

Title XVIII | Skilled Nursing Facility | PPS

	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: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 10/27/2015 8:26 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		110,099		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.674678	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.794176	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.380979	9,081	3,460	54.00
60.00	06000	LABORATORY	0.422260	36,760	15,522	60.00
64.00	06400	INTRAVENOUS THERAPY	0.171315	2,161	370	64.00
65.00	06500	RESPIRATORY THERAPY	0.153962	32,311	4,975	65.00
66.00	06600	PHYSICAL THERAPY	0.445268	1,002	446	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.489829	253	124	67.00
68.00	06800	SPEECH PATHOLOGY	0.461799	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.090454	796	72	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.214909	29,309	6,299	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406617	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379818	107,552	40,850	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	2.072267	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.439101	0	0	92.00
93.00	04950	WOUND CARE	0.755230	57	43	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		219,282	72,161	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)		219,282		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3

Component CCN: 14Z329 | Date/Time Prepared: 10/27/2015 8:26 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		6,101		30.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.674678	0	0	50.00
53.00	05300	ANESTHESIOLOGY	0.794176	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.380979	32,670	12,447	54.00
60.00	06000	LABORATORY	0.422260	112,039	47,310	60.00
64.00	06400	INTRAVENOUS THERAPY	0.171315	530	91	64.00
65.00	06500	RESPIRATORY THERAPY	0.153962	190,901	29,391	65.00
66.00	06600	PHYSICAL THERAPY	0.445268	444,500	197,922	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.489829	356,297	174,525	67.00
68.00	06800	SPEECH PATHOLOGY	0.461799	12,331	5,694	68.00
69.00	06900	ELECTROCARDIOLOGY	0.090454	1,254	113	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.214909	118,839	25,540	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.406617	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.379818	785,581	298,378	73.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
91.00	09100	EMERGENCY	2.072267	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.439101	0	0	92.00
93.00	04950	WOUND CARE	0.755230	144	109	93.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
200.00		Total (sum of lines 50-94 and 96-98)		2,055,086	791,520	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		2,055,086		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141329	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part B Date/Time Prepared: 10/27/2015 8:26 am
	Title XVIII	Hospital	Cost

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	1,331,085	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)	1,331,085	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	1,344,396	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)	6,248	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	349,359	26.00
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)	988,789	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)	988,789	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	988,789	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)	29,602	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	22,498	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	22,635	36.00
37.00	Subtotal (see instructions)	1,011,287	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,011,287	40.00
40.01	Sequestration adjustment (see instructions)	20,226	40.01
41.00	Interim payments	1,111,290	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-120,229	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: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 10/27/2015 8:26 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		163,088		1,095,418	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	01/13/2015	11,155	01/13/2015	50,805	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	06/09/2015	6,250	06/09/2015	34,933	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)		4,905		15,872	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)		167,993		1,111,290	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		10,251		120,229	6.02
7.00	Total Medicare program liability (see instructions)		157,742		991,061	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: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 10/27/2015 8:26 am

Component CCN: 14Z329 | 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		2,550,440		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	01/13/2015	77,094		0	3.01
3.02		06/09/2015	112,475		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)		189,569		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)		2,740,009		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		38,673		0	6.02
7.00	Total Medicare program liability (see instructions)		2,701,336		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: 141329	Period: From 07/01/2014 To 06/30/2015	Worksheet E-1 Part II Date/Time Prepared: 10/27/2015 8:26 am
	Title XVIII	Hospital	Cost

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	66	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	118	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	10	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	189	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	15,193,237	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	50,659	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 PPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

Provider CCN: 141329 | Component CCN: 14Z329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-2 | Date/Time Prepared: 10/27/2015 8:26 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)	2,000,885	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructions)	799,435	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	1,923	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)	2,800,320	0	8.00
9.00	Primary payer payments (see instructions)	0	0	9.00
10.00	Subtotal (line 8 minus line 9)	2,800,320	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)	2,800,320	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	59,089	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)	2,741,231	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)	23,321	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)	15,234	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	688	0	18.00
19.00	Total (see instructions)	2,756,465	0	19.00
19.01	Sequestration adjustment (see instructions)	55,129	0	19.01
20.00	Interim payments	2,740,009	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)	-38,673	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	0	0	23.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141329	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part V Date/Time Prepared: 10/27/2015 8:26 am
	Title XVIII	Hospital	Cost

		1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	193,725	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)	193,725	4.00
5.00	Primary payer payments	0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	195,662	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)	195,662	19.00
20.00	Deductibles (exclude professional component)	36,012	20.00
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	159,650	22.00
23.00	Coinsurance	0	23.00
24.00	Subtotal (line 22 minus line 23)	159,650	24.00
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1,725	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	1,311	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	569	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	160,961	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)	160,961	30.00
30.01	Sequestration adjustment (see instructions)	3,219	30.01
31.00	Interim payments	167,993	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)	-10,251	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 141329 Component CCN: 145274	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VI Date/Time Prepared: 10/27/2015 8:26 am
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	0	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	0	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	0	7.00
8.00	Allowable bad debts (see instructions)	0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	0	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Recovery of Accelerated Depreciation	0	14.99
15.00	Subtotal (see instructions	0	15.00
15.01	Sequestration adjustment (see instructions)	0	15.01
16.00	Interim payments	0	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)	0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 10/27/2015 8:26 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	1,205,858	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	1,932,142	0	0	0	4.00
5.00	Other receivable	991,085	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	212,207	0	0	0	7.00
8.00	Prepaid expenses	124,637	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	4,465,929	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	21,657	0	0	0	12.00
13.00	Land improvements	362,300	0	0	0	13.00
14.00	Accumulated depreciation	-259,373	0	0	0	14.00
15.00	Buildings	8,304,659	0	0	0	15.00
16.00	Accumulated depreciation	-4,815,064	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	4,413,383	0	0	0	23.00
24.00	Accumulated depreciation	-3,687,541	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)	4,340,021	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	393,965	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	393,965	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	9,199,915	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	320,771	0	0	0	37.00
38.00	Salaries, wages, and fees payable	404,762	0	0	0	38.00
39.00	Payroll taxes payable	95,827	0	0	0	39.00
40.00	Notes and loans payable (short term)	203,104	0	0	0	40.00
41.00	Deferred income	495,000	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	260,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	1,779,464	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	2,937,872	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	2,937,872	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	4,717,336	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	4,482,579				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)	4,482,579	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	9,199,915	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 10/27/2015 8:26 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		4,265,516		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-907,166				2.00
3.00	Total (sum of line 1 and line 2)		3,358,350		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)		3,358,350		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		3,358,350		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 10/27/2015 8:26 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	442,968		442,968	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	967,136		967,136	5.00
6.00	Swing bed - NF	64,731		64,731	6.00
7.00	SKILLED NURSING FACILITY	1,737,766		1,737,766	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)	3,212,601		3,212,601	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3,212,601		3,212,601	17.00
18.00	Ancillary services	2,260,180	5,626,970	7,887,150	18.00
19.00	Outpatient services	-602	982,798	982,196	19.00
20.00	RURAL HEALTH CLINIC	237,433	1,488,072	1,725,505	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	543,163	543,163	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NRCC	0	16,185	16,185	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	5,709,612	8,657,188	14,366,800	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		12,771,896		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		12,771,896		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 141329 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-3 | Date/Time Prepared: 10/27/2015 8:26 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	14,366,800	1.00
2.00	Less contractual allowances and discounts on patients' accounts	2,907,499	2.00
3.00	Net patient revenues (line 1 minus line 2)	11,459,301	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	12,771,896	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-1,312,595	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	9,853	6.00
7.00	Income from investments	38,260	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	264,986	24.00
24.01	COUNTY TAX REVENUE	944,554	24.01
24.02	STATE TAX REVENUE	89,076	24.02
24.03	ROUNDING	43	24.03
25.00	Total other income (sum of lines 6-24)	1,346,772	25.00
26.00	Total (line 5 plus line 25)	34,177	26.00
27.00	BAD DEBTS	884,989	27.00
27.01	CHARITY CARE	56,354	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	941,343	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-907,166	29.00

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

Provider CCN: 141329 Component CCN: 143981 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 10/27/2015 8:26 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	724,965	0	724,965	0	724,965	1.00
2.00	Physician Assistant	107,602	0	107,602	0	107,602	2.00
3.00	Nurse Practitioner	0	0	0	0	0	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5.00	Other Nurse	0	0	0	0	0	5.00
6.00	Clinical Psychologist	0	0	0	0	0	6.00
7.00	Clinical Social Worker	0	0	0	0	0	7.00
8.00	Laboratory Technician	0	0	0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	385,470	0	385,470	0	385,470	9.00
10.00	Subtotal (sum of lines 1 through 9)	1,218,037	0	1,218,037	0	1,218,037	10.00
11.00	Physician Services Under Agreement	0	810,582	810,582	-463,062	347,520	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	810,582	810,582	-463,062	347,520	14.00
15.00	Medical Supplies	0	67,132	67,132	0	67,132	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	146,238	146,238	-145,998	240	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	213,370	213,370	-145,998	67,372	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,218,037	1,023,952	2,241,989	-609,060	1,632,929	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	23,630	23,630	0	23,630	29.00
30.00	Administrative Costs	0	72,986	72,986	74,278	147,264	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	96,616	96,616	74,278	170,894	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	1,218,037	1,120,568	2,338,605	-534,782	1,803,823	32.00

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

Provider CCN: 141329 Component CCN: 143981 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 10/27/2015 8:26 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	724,965		1.00
2.00	Physician Assistant	-24,471	83,131		2.00
3.00	Nurse Practitioner	0	0		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	0		7.00
8.00	Laboratory Technician	0	0		8.00
9.00	Other Facility Health Care Staff Costs	0	385,470		9.00
10.00	Subtotal (sum of lines 1 through 9)	-24,471	1,193,566		10.00
11.00	Physician Services Under Agreement	0	347,520		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	347,520		14.00
15.00	Medical Supplies	0	67,132		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	240		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	67,372		21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-24,471	1,608,458		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	23,630		29.00
30.00	Administrative Costs	-30,192	117,072		30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	-30,192	140,702		31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-54,663	1,749,160		32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-2 | Date/Time Prepared: 10/27/2015 8:26 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	3.10	11,957	4,200	13,020		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.68	2,195	2,100	1,428		3.00
4.00	Subtotal (sum of lines 1 through 3)	3.78	14,152		14,448	14,448	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	0.24	340			340	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)	4.02	14,492			14,788	8.00
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES						
10.00	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,608,458	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)					0	11.00
12.00	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,608,458	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)					140,702	14.00
15.00	Parent provider overhead allocated to facility (see instructions)					687,267	15.00
16.00	Total overhead (sum of lines 14 and 15)					827,969	16.00
17.00	Allowable GME overhead (see instructions)					0	17.00
18.00	Subtotal (see instructions)					827,969	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)					827,969	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					2,436,427	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-3 | Date/Time Prepared: 10/27/2015 8:26 am

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

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		2,436,427	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		9,368	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		2,427,059	3.00
4.00	Total Visits (from Worksheet M-2, column 5, line 8)		14,788	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)		14,788	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		164.12	7.00

		Calculation of Limit (1)		
		Prior to January 1	On on After January 1	
		1.00	2.00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)	79.80	80.44	8.00
9.00	Rate for Program covered visits (see instructions)	164.12	164.12	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,709	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	280,481	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	1	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	164	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	164	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) *		280,645	16.00
16.01	Total program charges (see instructions)(from contractor's records)		251,851	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		133	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		148	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.)		208,960	16.04
16.05	Total program cost (see instructions)		209,108	16.05
17.00	Primary payer amounts		10	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		19,297	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		46,484	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		209,098	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		1,454	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		210,552	22.00
23.00	Allowable bad debts (see instructions)		12,733	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		9,677	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		12,025	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)		220,229	26.00
26.01	Sequestration adjustment (see instructions)		4,405	26.01
27.00	Interim payments		173,299	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)		42,525	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-4 | Date/Time Prepared: 10/27/2015 8:26 am

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,193,566	1,193,566	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000235	0.000585	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	280	698	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	2,600	2,606	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,880	3,304	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,608,458	1,608,458	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	827,969	827,969	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001791	0.002054	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,483	1,701	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	4,363	5,005	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	39	97	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	111.87	51.60	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	7	13	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	783	671	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		9,368	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		1,454	16.00

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

Provider CCN: 141329 | Component CCN: 143981 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-5 | Date/Time Prepared: 10/27/2015 8:26 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		177,447	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01		06/09/2015	3,017	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		01/13/2015	7,165	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)		-4,148	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		173,299	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		42,525	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		215,824	7.00

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