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: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet S Parts I-III Date/Time Prepared: 11/23/2015 9:53 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/23/2015 Time: 9:53 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MEMORIAL HOSP & HEALTH CARE CTR (150115) 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	97,071	47,494	17,285	0	1.00
2.00	Subprovider - IPF	0	6,867	0		0	2.00
3.00	Subprovider - IRF	0	-11,378	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	5,648	4		0	7.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		4,460		0	10.00
10.01	RURAL HEALTH CLINIC II	0		10,350		0	10.01
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	98,208	62,308	17,285	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: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/23/2015 9:52 am

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 800 WEST 9TH STREET	PO Box:			1.00
2.00	City: JASPER	State: IN	Zip Code: 47546	County: DUBOIS	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	MEMORIAL HOSP & HEALTH CARE CTR	150115	99915	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	MEMORIAL HOSP & HCC (PSYCH)	15S115	99915	4	07/01/1985	N	P	O	4.00
5.00	Subprovider - IRF	MEMORIAL HOSP & HCC (REHAB)	15T115	99915	5	07/01/2005	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	MEMORIAL HOSP & HEALTH CARE CTR	155305	99915		08/04/1987	N	P	O	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	MEMORIAL HOSP & HEALTH CARE CTR	157222	99915		08/28/1991	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC	FRENCH LICK FAMILY MEDICINE	158507	99915		06/19/2009	N	O	N	15.00
15.01	Hospital-Based Health Clinic - RHC II	LOOGOOTEE FAMILY MEDICINE	158508	99915		12/14/2009	N	O	N	15.01
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	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)	1		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.	Y	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)	Y	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	3	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	652	246	0	7	1,673	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I | Date/Time Prepared: 11/23/2015 9:52 am

		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	
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	15	0	0	0		25.00

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

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

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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

		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 9:52 am

		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

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

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

Line	Description	V 1.00	XIX 2.00	Line
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
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)?	N		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)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

Line	Description	Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00	Line
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.					109.00

Line	Description	1.00	Line
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

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

Line	Description	Premiums 1.00	Losses 2.00	Insurance 3.00	Line
118.01	List amounts of malpractice premiums and paid losses:	1,146,166	0	0	118.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 9:52 am

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part I Date/Time Prepared: 11/23/2015 9:52 am

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

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

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0.75	169.00

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

		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: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/23/2015 9:52 am

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

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

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

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

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

			Part A		Part B	
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)		Y	09/28/2015	Y	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/23/2015 9:52 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		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.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		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.		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		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		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.		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.		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.		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.		35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	BOB	BRANDENBURG	41.00
42.00	Enter the employer/company name of the cost report preparer.	BKD, LLP		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(317) 383-3787	BBRANDENBURG@BKD.COM	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet S-2 Part II Date/Time Prepared: 11/23/2015 9:52 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)	09/28/2015		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.			19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			21.00

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	PARTNER		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: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part I Date/Time Prepared: 11/23/2015 9:52 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	85	31,025	0.00	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)		85	31,025	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	26	9,490	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		111	40,515	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	19	6,935		0	16.00
17.00	SUBPROVIDER - IRF	41.00	8	2,920		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	20	7,300		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	116.00	0	0			24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		158				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: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet S-3 Part I Date/Time Prepared: 11/23/2015 9:52 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)	5,151	393	10,877			1.00
2.00	HMO and other (see instructions)	365	1,764				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	15				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	5,151	393	10,877			7.00
8.00	INTENSIVE CARE UNIT	2,812	163	4,298			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		77	2,021			13.00
14.00	Total (see instructions)	7,963	633	17,196	0.00	1,145.46	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,232	643	3,760	0.00	34.61	16.00
17.00	SUBPROVIDER - IRF	1,011	15	1,335	0.00	11.24	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	4,073	47	4,985	0.00	25.25	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	9,842	1,801	15,545	0.00	23.02	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	0.00	24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	1,350	0	3,528	0.00	3.61	26.00
26.01	RURAL HEALTH CLINIC II	2,094	0	6,597	0.00	6.26	26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1,249.45	27.00
28.00	Observation Bed Days		429	2,215			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	181	377			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

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	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	2,444	785	5,941	1.00
2.00	HMO and other (see instructions)			98	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,444	785	5,941	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	269	100	565	16.00
17.00	SUBPROVIDER - IRF	0.00	0	83	1	115	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	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.01	RURAL HEALTH CLINIC II	0.00					26.01
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					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

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	85,520,301	0	85,520,301	2,598,926.00	32.91	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		2,547,580	0	2,547,580	24,513.00	103.93	3.00
4.00	Physician-Part A - Administrative		205,584	0	205,584	800.00	256.98	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		6,716,276	0	6,716,276	36,624.00	183.38	5.00
6.00	Non-physician-Part B		492,924	0	492,924	16,366.00	30.12	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,212,605	14,848	1,227,453	52,519.00	23.37	9.00
10.00	Excluded area salaries (see instructions)		30,545,220	179,603	30,724,823	778,534.00	39.46	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		119,418	0	119,418	1,091.00	109.46	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		10,606,918	0	10,606,918			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		5,165,799	0	5,165,799			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		152,372	0	152,372			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		192,745	0	192,745			23.00
24.00	Wage-related costs (RHC/FQHC)		37,008	0	37,008			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,706,884	-842,778	864,106	15,752.00	54.86	26.00
27.00	Administrative & General	5.00	7,643,942	282,179	7,926,121	300,562.00	26.37	27.00
28.00	Administrative & General under contract (see inst.)		104,450	0	104,450	536.00	194.87	28.00
29.00	Maintenance & Repairs	6.00	1,554,748	19,476	1,574,224	68,221.00	23.08	29.00
30.00	Operation of Plant	7.00	0	0	0	0.00	0.00	30.00
31.00	Laundry & Linen Service	8.00	214,693	4,116	218,809	18,735.00	11.68	31.00
32.00	Housekeeping	9.00	953,574	14,718	968,292	80,622.00	12.01	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,024,910	-683,966	340,944	21,879.00	15.58	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	702,997	702,997	47,780.00	14.71	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	885,239	8,584	893,823	28,041.00	31.88	38.00
39.00	Central Services and Supply	14.00	225,402	4,029	229,431	15,819.00	14.50	39.00
40.00	Pharmacy	15.00	1,782,308	16,380	1,798,688	47,460.00	37.90	40.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part II Date/Time Prepared: 11/23/2015 9:52 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medical Records & Medical Records Library	16.00	1,028,596	16,057	1,044,653	53,773.00	19.43	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part III Date/Time Prepared: 11/23/2015 9:52 am

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		75,867,971	0	75,867,971	2,521,959.00	30.08	1.00
2.00	Excluded area salaries (see instructions)		31,757,825	194,451	31,952,276	831,053.00	38.45	2.00
3.00	Subtotal salaries (line 1 minus line 2)		44,110,146	-194,451	43,915,695	1,690,906.00	25.97	3.00
4.00	Subtotal other wages & related costs (see inst.)		119,418	0	119,418	1,091.00	109.46	4.00
5.00	Subtotal wage-related costs (see inst.)		10,606,918	0	10,606,918	0.00	24.15	5.00
6.00	Total (sum of lines 3 thru 5)		54,836,482	-194,451	54,642,031	1,691,997.00	32.29	6.00
7.00	Total overhead cost (see instructions)		17,124,746	-458,208	16,666,538	699,180.00	23.84	7.00

HOSPITAL WAGE RELATED COSTS	Provider CCN: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet S-3 Part IV Date/Time Prepared: 11/23/2015 9:52 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	1,367,570	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	-327,679	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	8,951,286	8.00
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	69,879	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	221,671	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	353,072	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	5,207,311	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	52,641	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	259,091	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	16,154,842	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-3 Part V Date/Time Prepared: 11/23/2015 9:52 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	0	13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
14.01	Hospital-Based Health Clinic RHC 1	0	0	14.01
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA

Provider CCN: 150115 | Component CCN: 157222 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-4 | Date/Time Prepared: 11/23/2015 9:52 am

Home Health Agency I | PPS

		1.00	
0.00	County		0.00

		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	6,386	492	1,823	8,701	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	480.00	37.00	137.00	654.00	2.00

		Enter the number of hours in your normal work week	Number of Employees (Full Time Equivalent) Staff	Contract	Total	
		0	1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES					
3.00	Administrator and Assistant Administrator(s)	0.00	0.00	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		1.00	0.00	1.00	4.00
5.00	Other Administrative Personnel		4.70	0.00	4.70	5.00
6.00	Direct Nursing Service		10.29	0.00	10.29	6.00
7.00	Nursing Supervisor		0.16	0.00	0.16	7.00
8.00	Physical Therapy Service		1.78	0.00	1.78	8.00
9.00	Physical Therapy Supervisor		0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service		0.81	0.00	0.81	10.00
11.00	Occupational Therapy Supervisor		0.00	0.00	0.00	11.00
12.00	Speech Pathology Service		0.09	0.00	0.09	12.00
13.00	Speech Pathology Supervisor		0.00	0.00	0.00	13.00
14.00	Medical Social Service		0.00	0.00	0.00	14.00
15.00	Medical Social Service Supervisor		4.18	0.00	4.18	15.00
16.00	Home Health Aide		0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor		0.00	0.00	0.00	17.00
18.00	Other (specify)		0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES					
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.		2			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).		99915			20.00
20.01			50031			20.01

		Full Episodes Without Outliers	Full Episodes With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	4,039	505	202	136	4,882	21.00
22.00	Skilled Nursing Visit Charges	696,475	92,359	29,056	22,611	840,501	22.00
23.00	Physical Therapy Visits	2,080	43	13	69	2,205	23.00
24.00	Physical Therapy Visit Charges	413,972	8,400	2,600	13,800	438,772	24.00
25.00	Occupational Therapy Visits	641	2	3	41	687	25.00
26.00	Occupational Therapy Visit Charges	127,972	400	600	8,200	137,172	26.00
27.00	Speech Pathology Visits	23	0	0	2	25	27.00
28.00	Speech Pathology Visit Charges	4,600	0	0	400	5,000	28.00
29.00	Medical Social Service Visits	0	1	0	0	1	29.00
30.00	Medical Social Service Visit Charges	0	228	0	0	228	30.00
31.00	Home Health Aide Visits	1,778	184	4	76	2,042	31.00
32.00	Home Health Aide Visit Charges	150,681	15,308	258	6,364	172,611	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	8,561	735	222	324	9,842	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1,393,700	116,695	32,514	51,375	1,594,284	35.00
36.00	Total Number of Episodes (standard/non outlier)	448		59	20	527	36.00
37.00	Total Number of Outlier Episodes		15		1	16	37.00
38.00	Total Non-Routine Medical Supply Charges	52,334	5,272	1,028	1,027	59,661	38.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-7 Date/Time Prepared: 11/23/2015 9:52 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.			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.			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	20	0	20	12.00
13.00	RUB	0	0	0	13.00
14.00	RUA	0	0	0	14.00
15.00	RVC	96	0	96	15.00
16.00	RVB	648	0	648	16.00
17.00	RVA	79	0	79	17.00
18.00	RHC	928	0	928	18.00
19.00	RHB	1,484	0	1,484	19.00
20.00	RHA	306	0	306	20.00
21.00	RMC	47	0	47	21.00
22.00	RMB	84	0	84	22.00
23.00	RMA	74	0	74	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	28	0	28	27.00
28.00	ES1	0	0	0	28.00
29.00	HE2	0	0	0	29.00
30.00	HE1	5	0	5	30.00
31.00	HD2	14	0	14	31.00
32.00	HD1	28	0	28	32.00
33.00	HC2	16	0	16	33.00
34.00	HC1	33	0	33	34.00
35.00	HB2	13	0	13	35.00
36.00	HB1	13	0	13	36.00
37.00	LE2	0	0	0	37.00
38.00	LE1	8	0	8	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	14	0	14	42.00
43.00	LB2	0	0	0	43.00
44.00	LB1	1	0	1	44.00
45.00	CE2	0	0	0	45.00
46.00	CE1	7	0	7	46.00
47.00	CD2	0	0	0	47.00
48.00	CD1	13	0	13	48.00
49.00	CC2	0	0	0	49.00
50.00	CC1	65	0	65	50.00
51.00	CB2	0	0	0	51.00
52.00	CB1	21	0	21	52.00
53.00	CA2	0	0	0	53.00
54.00	CA1	10	0	10	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: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-7 | Date/Time Prepared: 11/23/2015 9:52 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	4	0	4	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	6	0	6	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	8	0	8	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		4,073	0	4,073	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).	99915	99915	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	0	0.00		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)	1,465,117			207.00

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

Provider CCN: 150115 | Component CCN: 158507 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-8 | Date/Time Prepared: 11/23/2015 9:52 am

Rural Health Clinic (RHC) I | Cost

		1.00	
	Clinic Address and Identification		
1.00	Street	522 SOUTH MAPLE STREET	1.00

		City	State	ZIP Code	
		1.00	2.00	3.00	
2.00	City, State, ZIP Code, County	FRENCH LICK	IN	47432	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 from	Sunday to	Monday from	Monday to	Tuesday from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)						
11.00	Clinic			08:00	17:00	07:00	11.00

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

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

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

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

		Tuesday to	Wednesday from	Wednesday to	Thursday from	Thursday to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	16:00	08:00	12:00	07:00	16:00	11.00

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

Provider CCN: 150115 | Component CCN: 158507 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-8 | Date/Time Prepared: 11/23/2015 9:52 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	06:00	15:00				11.00

HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER STATISTICAL DATA	Provider CCN: 150115 Component CCN: 158508	Period: From 07/01/2014 To 06/30/2015	Worksheet S-8 Date/Time Prepared: 11/23/2015 9:52 am
		Rural Health Clinic (RHC) II	Cost

				1.00		
	Clinic Address and Identification					
1.00	Street			105 COOPER STREET		1.00
			City	State	ZIP Code	
			1.00	2.00	3.00	
2.00	City, State, ZIP Code, County		LOOGOOTEE	IN	47553	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	18:00	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)						15.00

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

		Tuesday	Wednesday		Thursday		
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	Clinic	18:00	08:00	18:00	08:00	18:00	11.00

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

Provider CCN: 150115 | Component CCN: 158508 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-8 | Date/Time Prepared: 11/23/2015 9:52 am

Rural Health Clinic (RHC) II | Cost

		Friday		Saturday			
		from	to	from	to		
		11.00	12.00	13.00	14.00		
	Facility hours of operations (1)						
11.00	Clinic	08:00	12:00				11.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet S-10 | Date/Time Prepared: 11/23/2015 9:52 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)	0.364014	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	7,285,966	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	41,700,416	6.00
7.00	Medicaid cost (line 1 times line 6)	15,179,535	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)	7,893,569	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)	7,893,569	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	3,216,273	0	3,216,273	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	1,170,768	0	1,170,768	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	1,170,768	0	1,170,768	23.00

		1.00	
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	9,099,199	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	276,491	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	8,822,708	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	3,211,589	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	4,382,357	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	12,275,926	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/23/2015 9:52 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		7,925,919	7,925,919	0	7,925,919	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		8,535,826	8,535,826	0	8,535,826	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,706,884	16,646,986	18,353,870	-842,778	17,511,092	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,643,942	15,328,081	22,972,023	282,167	23,254,190	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,554,748	5,867,023	7,421,771	19,476	7,441,247	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	214,693	109,867	324,560	4,116	328,676	8.00
9.00	00900	HOUSEKEEPING	953,574	269,360	1,222,934	14,718	1,237,652	9.00
10.00	01000	DIETARY	1,024,910	708,241	1,733,151	-1,195,334	537,817	10.00
11.00	01100	CAFETERIA	0	0	0	1,188,787	1,188,787	11.00
13.00	01300	NURSING ADMINISTRATION	885,239	137,949	1,023,188	7,956	1,031,144	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	225,402	231,200	456,602	-174,845	281,757	14.00
15.00	01500	PHARMACY	1,782,308	10,086,670	11,868,978	16,380	11,885,358	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,028,596	152,246	1,180,842	16,057	1,196,899	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	5,896,987	595,495	6,492,482	-2,174,482	4,318,000	30.00
31.00	03100	INTENSIVE CARE UNIT	2,405,619	270,114	2,675,733	-1,607	2,674,126	31.00
40.00	04000	SUBPROVIDER - IPF	2,097,192	89,485	2,186,677	13,954	2,200,631	40.00
41.00	04100	SUBPROVIDER - IRF	608,333	157,537	765,870	2,591	768,461	41.00
43.00	04300	NURSERY	0	0	0	686,605	686,605	43.00
44.00	04400	SKILLED NURSING FACILITY	1,212,605	59,874	1,272,479	9,192	1,281,671	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,404,753	9,582,925	13,987,678	-2,671,976	11,315,702	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	1,258,776	1,258,776	52.00
53.00	05300	ANESTHESIOLOGY	3,272,339	717,705	3,990,044	-224,189	3,765,855	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,851,131	827,287	4,678,418	-86,108	4,592,310	54.00
56.00	05600	RADIOISOTOPE	212,740	586,212	798,952	-1,978	796,974	56.00
60.00	06000	LABORATORY	2,277,129	3,917,782	6,194,911	26,111	6,221,022	60.00
65.00	06500	RESPIRATORY THERAPY	980,828	345,486	1,326,314	-195,828	1,130,486	65.00
66.00	06600	PHYSICAL THERAPY	1,892,139	346,081	2,238,220	-30,545	2,207,675	66.00
69.00	06900	ELECTROCARDIOLOGY	2,072,012	3,065,940	5,137,952	-2,655,010	2,482,942	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	92,958	7,848	100,806	-3,022	97,784	69.02
69.03	06903	SLEEP LAB	183,532	47,545	231,077	-8,073	223,004	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,155,970	7,155,970	-2,541,434	4,614,536	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,317,329	9,317,329	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	239,168	109,413	348,581	1,016	349,597	88.00
88.01	08801	RURAL HEALTH CLINIC II	434,020	58,421	492,441	1,538	493,979	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	243,278	821,487	1,064,765	-33,875	1,030,890	90.00
90.01	09001	IMED	353,035	123,139	476,174	2,289	478,463	90.01
90.02	09002	ONCOLOGY	1,242,795	1,019,457	2,262,252	-13,986	2,248,266	90.02
90.03	09003	OUTPATIENT CENTER	214,531	81,403	295,934	2,244	298,178	90.03
91.00	09100	EMERGENCY	6,473,186	845,711	7,318,897	-68,718	7,250,179	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,668,468	173,576	1,842,044	-7,169	1,834,875	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	1,231,881	268,847	1,500,728	-16,437	1,484,291	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	60,580,955	97,274,108	157,855,063	-76,092	157,778,971	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	21,794,551	5,616,983	27,411,534	20,140	27,431,674	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	698,238	10,937	709,175	2,350	711,525	192.01
194.00	07950	LODGE	72	143	215	0	215	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	130,726	3,677	134,403	4,986	139,389	194.02
194.03	07953	MKT/PHY SERVICES	1,591,068	1,743,266	3,334,334	35,325	3,369,659	194.03
194.04	07954	COMMUNITY EDUCATION	373,227	153,916	527,143	4,837	531,980	194.04
194.05	07955	VOLUNTEER	155,480	7,998	163,478	1,430	164,908	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	195,984	567,792	763,776	7,024	770,800	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
200.00		TOTAL (SUM OF LINES 118-199)	85,520,301	105,378,820	190,899,121	0	190,899,121	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A | Date/Time Prepared: 11/23/2015 9:52 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	-2,194,799	5,731,120	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	32,529	8,568,355	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-1,493,653	16,017,439	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-586,412	22,667,778	5.00
6.00	00600	MAINTENANCE & REPAIRS	-79,528	7,361,719	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	328,676	8.00
9.00	00900	HOUSEKEEPING	0	1,237,652	9.00
10.00	01000	DIETARY	-31,022	506,795	10.00
11.00	01100	CAFETERIA	-568,413	620,374	11.00
13.00	01300	NURSING ADMINISTRATION	-3,196	1,027,948	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	281,757	14.00
15.00	01500	PHARMACY	-214,810	11,670,548	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-58,815	1,138,084	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	4,318,000	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,674,126	31.00
40.00	04000	SUBPROVIDER - IPF	-521,574	1,679,057	40.00
41.00	04100	SUBPROVIDER - IRF	-59,750	708,711	41.00
43.00	04300	NURSERY	0	686,605	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,281,671	44.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-2,388,979	8,926,723	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,258,776	52.00
53.00	05300	ANESTHESIOLOGY	-3,414,392	351,463	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,208,453	3,383,857	54.00
56.00	05600	RADIOISOTOPE	0	796,974	56.00
60.00	06000	LABORATORY	-150,000	6,071,022	60.00
65.00	06500	RESPIRATORY THERAPY	-2,286	1,128,200	65.00
66.00	06600	PHYSICAL THERAPY	-5,062	2,202,613	66.00
69.00	06900	ELECTROCARDIOLOGY	-402,265	2,080,677	69.00
69.01	06901	PULMONARY	0	0	69.01
69.02	06902	CARDIOPULMONARY	-7,470	90,314	69.02
69.03	06903	SLEEP LAB	-4,106	218,898	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,614,536	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,317,329	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	-3,829	345,768	88.00
88.01	08801	RURAL HEALTH CLINIC II	-19,850	474,129	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-321,308	709,582	90.00
90.01	09001	IMED	-191,458	287,005	90.01
90.02	09002	ONCOLOGY	-1,256	2,247,010	90.02
90.03	09003	OUTPATIENT CENTER	0	298,178	90.03
91.00	09100	EMERGENCY	-4,097,186	3,152,993	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	-17,295	1,817,580	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	1,484,291	101.00
	SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-18,014,638	139,764,333	118.00
	NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	27,431,674	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	711,525	192.01
194.00	07950	LODGE	0	215	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	139,389	194.02
194.03	07953	MKT/PHY SERVICES	0	3,369,659	194.03
194.04	07954	COMMUNITY EDUCATION	0	531,980	194.04
194.05	07955	VOLUNTEER	0	164,908	194.05
194.06	07956	MAB	0	0	194.06
194.08	07958	PUBLIC RELATIONS	0	770,800	194.08
194.09	07959	UNUSED SPACE	0	0	194.09
200.00		TOTAL (SUM OF LINES 118-199)	-18,014,638	172,884,483	200.00

RECLASSIFICATIONS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 | Date/Time Prepared: 11/23/2015 9:52 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	B - LABOR AND DELIVERY				
1.00	DELIVERY ROOM & LABOR ROOM	52.00	1,091,371	167,405	1.00
2.00	NURSERY	43.00	595,293	91,312	2.00
	0		1,686,664	258,717	
	C - CAFETERIA				
1.00	CAFETERIA	11.00	702,997	485,790	1.00
	0		702,997	485,790	
	D - IMPLANTABLE DEVICES				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,317,329	1.00
	0		0	9,317,329	
	E - BILLABLE SUPPLES				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	6,775,895	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
	0		0	6,775,895	
	F - GAINSHARE RECLASS				
1.00	ADMINISTRATIVE & GENERAL	5.00	282,179	0	1.00
2.00	MAINTENANCE & REPAIRS	6.00	19,476	0	2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	4,116	0	3.00
4.00	HOUSEKEEPING	9.00	14,718	0	4.00
5.00	DIETARY	10.00	19,031	0	5.00
6.00	NURSING ADMINISTRATION	13.00	8,584	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	4,029	0	7.00
8.00	PHARMACY	15.00	16,380	0	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	16,057	0	9.00
10.00	ADULTS & PEDIATRICS	30.00	59,679	0	10.00
11.00	INTENSIVE CARE UNIT	31.00	22,024	0	11.00
12.00	SUBPROVIDER - IPF	40.00	17,368	0	12.00
13.00	SUBPROVIDER - IRF	41.00	4,953	0	13.00
14.00	SKILLED NURSING FACILITY	44.00	14,848	0	14.00
15.00	OPERATING ROOM	50.00	33,880	0	15.00
16.00	ANESTHESIOLOGY	53.00	964	0	16.00
17.00	RADIOLOGY-DIAGNOSTIC	54.00	24,608	0	17.00
18.00	RADIOISOTOPE	56.00	1,374	0	18.00
19.00	LABORATORY	60.00	26,111	0	19.00
20.00	RESPIRATORY THERAPY	65.00	10,657	0	20.00
21.00	PHYSICAL THERAPY	66.00	20,451	0	21.00
22.00	ELECTROCARDIOLOGY	69.00	16,830	0	22.00
23.00	CARDIOPULMONARY	69.02	530	0	23.00
24.00	SLEEP LAB	69.03	1,939	0	24.00
25.00	RURAL HEALTH CLINIC	88.00	1,016	0	25.00
26.00	RURAL HEALTH CLINIC II	88.01	1,538	0	26.00
27.00	CLINIC	90.00	2,547	0	27.00
28.00	IMED	90.01	2,289	0	28.00
29.00	ONCOLOGY	90.02	11,917	0	29.00
30.00	OUTPATIENT CENTER	90.03	2,244	0	30.00
31.00	EMERGENCY	91.00	23,159	0	31.00
32.00	AMBULANCE SERVICES	95.00	21,424	0	32.00
33.00	HOME HEALTH AGENCY	101.00	13,190	0	33.00
34.00	PHYSICIANS' PRIVATE OFFICES	192.00	66,716	0	34.00

RECLASSIFICATIONS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-6 Date/Time Prepared: 11/23/2015 9:52 am

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
35.00	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	192.01	2,350	0	35.00
36.00	MEMORIAL HOSPITAL FOUNDATION	194.02	4,986	0	36.00
37.00	MKT/PHY SERVICES	194.03	35,325	0	37.00
38.00	COMMUNITY EDUCATION	194.04	4,837	0	38.00
39.00	VOLUNTEER	194.05	1,430	0	39.00
40.00	PUBLIC RELATIONS	194.08	7,024	0	40.00
	O		842,778	0	
500.00	Grand Total: Increases		3,232,439	16,837,731	500.00

	Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	B - LABOR AND DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	1,686,664	258,717	0	1.00
2.00		0.00	0	0	0	2.00
	0		1,686,664	258,717		
	C - CAFETERIA					
1.00	DIETARY	10.00	702,997	485,790	0	1.00
	0		702,997	485,790		
	D - IMPLANTABLE DEVICES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	9,317,329	0	1.00
	0		0	9,317,329		
	E - BILLABLE SUPPLES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12	0	1.00
2.00	DIETARY	10.00	0	25,578	0	2.00
3.00	NURSING ADMINISTRATION	13.00	0	628	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	178,874	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	288,780	0	5.00
6.00	INTENSIVE CARE UNIT	31.00	0	23,631	0	6.00
7.00	SUBPROVIDER - IPF	40.00	0	3,414	0	7.00
8.00	SUBPROVIDER - IRF	41.00	0	2,362	0	8.00
9.00	SKILLED NURSING FACILITY	44.00	0	5,656	0	9.00
10.00	OPERATING ROOM	50.00	0	2,705,856	0	10.00
11.00	ANESTHESIOLOGY	53.00	0	225,153	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	110,716	0	12.00
13.00	RADIOISOTOPE	56.00	0	3,352	0	13.00
14.00	RESPIRATORY THERAPY	65.00	0	206,485	0	14.00
15.00	PHYSICAL THERAPY	66.00	0	50,996	0	15.00
16.00	ELECTROCARDIOLOGY	69.00	0	2,671,840	0	16.00
17.00	CARDIOPULMONARY	69.02	0	3,552	0	17.00
18.00	SLEEP LAB	69.03	0	10,012	0	18.00
19.00	CLINIC	90.00	0	36,422	0	19.00
20.00	ONCOLOGY	90.02	0	25,903	0	20.00
21.00	EMERGENCY	91.00	0	91,877	0	21.00
22.00	AMBULANCE SERVICES	95.00	0	28,593	0	22.00
23.00	HOME HEALTH AGENCY	101.00	0	29,627	0	23.00
24.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	46,576	0	24.00
	0		0	6,775,895		
	F - GAINSHARE RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	842,778	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
4.00		0.00	0	0	0	4.00
5.00		0.00	0	0	0	5.00
6.00		0.00	0	0	0	6.00
7.00		0.00	0	0	0	7.00
8.00		0.00	0	0	0	8.00
9.00		0.00	0	0	0	9.00
10.00		0.00	0	0	0	10.00
11.00		0.00	0	0	0	11.00
12.00		0.00	0	0	0	12.00
13.00		0.00	0	0	0	13.00
14.00		0.00	0	0	0	14.00
15.00		0.00	0	0	0	15.00
16.00		0.00	0	0	0	16.00
17.00		0.00	0	0	0	17.00
18.00		0.00	0	0	0	18.00
19.00		0.00	0	0	0	19.00
20.00		0.00	0	0	0	20.00
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
27.00		0.00	0	0	0	27.00
28.00		0.00	0	0	0	28.00
29.00		0.00	0	0	0	29.00
30.00		0.00	0	0	0	30.00
31.00		0.00	0	0	0	31.00
32.00		0.00	0	0	0	32.00
33.00		0.00	0	0	0	33.00
34.00		0.00	0	0	0	34.00
35.00		0.00	0	0	0	35.00
36.00		0.00	0	0	0	36.00

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
37.00		0.00	0	0	0		37.00
38.00		0.00	0	0	0		38.00
39.00		0.00	0	0	0		39.00
40.00		0.00	0	0	0		40.00
	0		842,778	0			
500.00	Grand Total: Decreases		3,232,439	16,837,731			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part I Date/Time Prepared: 11/23/2015 9:52 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	6,145,421	1,440,527	0	1,440,527	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	109,955,416	0	0	0	23,444	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	88,581,413	7,083,874	0	7,083,874	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	204,682,250	8,524,401	0	8,524,401	23,444	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	204,682,250	8,524,401	0	8,524,401	23,444	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	7,585,948	0	1.00
2.00	Land Improvements	0	0	2.00
3.00	Buildings and Fixtures	109,931,972	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	0	0	5.00
6.00	Movable Equipment	95,665,287	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	213,183,207	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	213,183,207	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part II Date/Time Prepared: 11/23/2015 9:52 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	3,900,164	1,114,278	2,728,746	182,731	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	8,535,826	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	12,435,990	1,114,278	2,728,746	182,731	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	7,925,919	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	8,535,826	2.00
3.00	Total (sum of lines 1-2)	0	16,461,745	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-7 Part III Date/Time Prepared: 11/23/2015 9:52 am

	Cost Center Description	COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	117,517,920	0	117,517,920	0.551253	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	95,665,287	0	95,665,287	0.448747	0	2.00
3.00	Total (sum of lines 1-2)	213,183,207	0	213,183,207	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	3,810,679	1,113,918	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	8,568,355	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	12,379,034	1,113,918	3.00

	Cost Center Description	SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	623,792	182,731	0	0	5,731,120	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	8,568,355	2.00
3.00	Total (sum of lines 1-2)	623,792	182,731	0	0	14,299,475	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/23/2015 9:52 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		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	-10,791	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-10,640,651			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	B	-13,745	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	-1,470,670			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-568,413	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients	B	-214,810	PHARMACY	15.00	0	17.00
18.00	Sale of medical records and abstracts	B	-58,815	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	B	-406	ADMINISTRATIVE & GENERAL	5.00	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	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	TELEPHONE DEPRECIATION	A	-89,485	CAP REL COSTS-BLDG & FIXT	1.00	9	33.00
33.01	CRNA	A	-908,684	OPERATING ROOM	50.00	0	33.01

ADJUSTMENTS TO EXPENSES | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8 | Date/Time Prepared: 11/23/2015 9:52 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
				Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.02	MISCELLANEOUS REVENUE	B	-41,043	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADVERTISING - BENEFITS	A	-23,087	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
33.04	MAINTENANCE	B	-30,297	MAINTENANCE & REPAIRS	6.00	0	33.04
33.05	ADVERTISING - FRENCH LICK	A	-3,136	RURAL HEALTH CLINIC	88.00	0	33.05
33.06	ADVERTISING - LOOGOOTEE	A	-1,027	RURAL HEALTH CLINIC II	88.01	0	33.06
33.07	ADVERTISING - AMBULANCE	A	-4,300	AMBULANCE SERVICES	95.00	0	33.07
33.08	ADVERTISING - CARING HANDS	A	-766	SUBPROVIDER - IPF	40.00	0	33.08
33.09	DIETARY SUPPLEMENTS	B	-27,100	DIETARY	10.00	0	33.09
33.10	CLINICAL ENGINEERING	B	-888	MAINTENANCE & REPAIRS	6.00	0	33.10
33.11	MISCELLANEOUS - DIETARY	B	-3,922	DIETARY	10.00	0	33.11
33.12	ADVERTISING - HOME CARE	A	-371	RESPIRATORY THERAPY	65.00	0	33.12
33.13	MISCELLANEOUS - FINANCE	B	-90,773	ADMINISTRATIVE & GENERAL	5.00	0	33.13
33.14	MISCELLANEOUS - AMBULANCE	B	-12,995	AMBULANCE SERVICES	95.00	0	33.14
33.15	ACCOUNTS PAYABLE DISCOUNT	B	-39,900	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	MISCELLANEOUS - SLEEP LAB	B	-3,700	SLEEP LAB	69.03	0	33.16
33.17	BUILDING RENTAL INCOME	B	-360	CAP REL COSTS-BLDG & FIXT	1.00	10	33.17
33.18	MISCELLANEOUS - CLINCAL	B	-3,196	NURSING ADMINISTRATION	13.00	0	33.18
33.19	MISCELLANEOUS - FRENCH LICK	B	-693	RURAL HEALTH CLINIC	88.00	0	33.19
33.20	MISCELLANEOUS - LOOGOOTEE	B	-18,823	RURAL HEALTH CLINIC II	88.01	0	33.20
33.21	MISCELLANEOUS - CARDIAC REHAB	B	-7,470	CARDIOPULMONARY	69.02	0	33.21
33.22	MISCELLANEOUS - VASCULAR	B	-3,150	ELECTROCARDIOLOGY	69.00	0	33.22
33.24	CRNA EXPENSE	A	-1,638,896	ANESTHESIOLOGY	53.00	0	33.24
33.25	MISC. PROC. CENTER	B	-2,080	ADMINISTRATIVE & GENERAL	5.00	0	33.25
33.27	AHA & IHA LOBBYING DUES	A	-8,073	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	INTEREST	B	-2,104,954	CAP REL COSTS-BLDG & FIXT	1.00	11	33.28
33.29	START-UP COST OFFSET	A	32,529	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.29
33.30	START-UP COST OFFSET	A	51,698	SUBPROVIDER - IPF	40.00	0	33.30
33.33	CABLE TV EXPENSE	A	-48,343	MAINTENANCE & REPAIRS	6.00	0	33.33
33.35	ADVERTISING - AUDIOLOGY	A	-1,390	PHYSICAL THERAPY	66.00	0	33.35
33.36	ADVERTISING - SLEEP CENTER	A	-406	SLEEP LAB	69.03	0	33.36
33.37	ADVERTISING - ONCOLOGY	A	-1,256	ONCOLOGY	90.02	0	33.37
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-18,014,638				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8-1 Date/Time Prepared: 11/23/2015 9:52 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	50.00	OPERATING ROOM	AMBULATORY SURGERY CENTER	3,565,013	5,035,683	1.00
2.00	0.00			0	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			3,565,013	5,035,683	5.00

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

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

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

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

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
6.00	C	MHHCC	0.00	MEM HOS OP SURG	40.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS	Provider CCN: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet A-8-1 Date/Time Prepared: 11/23/2015 9:52 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	6.00	7.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:		
1.00	-1,470,670	0	1.00
2.00	0	0	2.00
3.00	0	0	3.00
4.00	0	0	4.00
5.00	-1,470,670		5.00

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

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

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

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

6.00	SURGERY CENTER	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet A-8-2 | Date/Time Prepared: 11/23/2015 9:52 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	4.00	EMPLOYEE BENEFITS DEPARTMENT	1,470,566	1,470,566	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	379,601	379,601	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	572,506	572,506	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	131,000	21,000	110,000	142,500	1,040	4.00
5.00	50.00	OPERATING ROOM	9,625	9,625	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	1,775,496	1,775,496	0	0	0	6.00
7.00	60.00	LABORATORY	150,000	150,000	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	1,915	1,915	0	0	0	8.00
9.00	66.00	PHYSICAL THERAPY	4,672	3,672	1,000	142,500	41	9.00
10.00	69.00	ELECTROCARDIOLOGY	453,923	248,339	205,584	142,500	800	10.00
11.00	90.00	CLINIC	321,308	321,308	0	0	0	11.00
12.00	90.01	IMED	191,458	191,458	0	0	0	12.00
13.00	91.00	EMERGENCY	4,097,871	4,089,453	8,418	142,500	10	13.00
14.00	54.00	RADIOLOGY-DIAGNOSTIC	1,208,453	1,208,453	0	0	0	14.00
200.00			10,768,394	10,443,392	325,002		1,891	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	3.00
4.00	41.00	SUBPROVIDER - IRF	71,250	3,563	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	6.00
7.00	60.00	LABORATORY	0	0	0	0	0	7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	8.00
9.00	66.00	PHYSICAL THERAPY	2,809	140	0	0	0	9.00
10.00	69.00	ELECTROCARDIOLOGY	54,808	2,740	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	90.01	IMED	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	685	34	0	0	0	13.00
14.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	14.00
200.00			129,552	6,477	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	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	0	1,470,566		1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	379,601		2.00
3.00	40.00	SUBPROVIDER - IPF	0	0	0	572,506		3.00
4.00	41.00	SUBPROVIDER - IRF	0	71,250	38,750	59,750		4.00
5.00	50.00	OPERATING ROOM	0	0	0	9,625		5.00
6.00	53.00	ANESTHESIOLOGY	0	0	0	1,775,496		6.00
7.00	60.00	LABORATORY	0	0	0	150,000		7.00
8.00	65.00	RESPIRATORY THERAPY	0	0	0	1,915		8.00
9.00	66.00	PHYSICAL THERAPY	0	2,809	0	3,672		9.00
10.00	69.00	ELECTROCARDIOLOGY	0	54,808	150,776	399,115		10.00
11.00	90.00	CLINIC	0	0	0	321,308		11.00
12.00	90.01	IMED	0	0	0	191,458		12.00
13.00	91.00	EMERGENCY	0	685	7,733	4,097,186		13.00
14.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	1,208,453		14.00
200.00			0	129,552	197,259	10,640,651		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I | Date/Time Prepared: 11/23/2015 9:52 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	5,731,120	5,731,120				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	8,568,355		8,568,355			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	16,017,439	32,414	48,460	16,098,313		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,667,778	1,222,982	1,828,430	1,507,239	27,226,429	5.00
6.00	00600	MAINTENANCE & REPAIRS	7,361,719	417,173	623,698	299,356	8,701,946	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	328,676	21,116	31,570	41,609	422,971	8.00
9.00	00900	HOUSEKEEPING	1,237,652	18,188	27,192	184,131	1,467,163	9.00
10.00	01000	DIETARY	506,795	71,754	107,276	64,834	750,659	10.00
11.00	01100	CAFETERIA	620,374	14,473	21,638	133,683	790,168	11.00
13.00	01300	NURSING ADMINISTRATION	1,027,948	12,608	18,850	169,970	1,229,376	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	281,757	12,244	18,306	43,629	355,936	14.00
15.00	01500	PHARMACY	11,670,548	39,676	59,317	342,040	12,111,581	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,138,084	33,229	49,680	198,652	1,419,645	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,318,000	372,748	557,280	811,988	6,060,016	30.00
31.00	03100	INTENSIVE CARE UNIT	2,674,126	151,470	226,456	461,643	3,513,695	31.00
40.00	04000	SUBPROVIDER - IPF	1,679,057	119,661	178,899	402,107	2,379,724	40.00
41.00	04100	SUBPROVIDER - IRF	708,711	62,431	93,337	116,623	981,102	41.00
43.00	04300	NURSERY	686,605	47,025	70,305	113,202	917,137	43.00
44.00	04400	SKILLED NURSING FACILITY	1,281,671	82,068	122,697	233,414	1,719,850	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,926,723	407,063	608,583	844,055	10,786,424	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,258,776	86,184	128,849	207,536	1,681,345	52.00
53.00	05300	ANESTHESIOLOGY	351,463	0	0	622,455	973,918	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,383,857	151,258	226,140	737,014	4,498,269	54.00
56.00	05600	RADIOISOTOPE	796,974	12,929	19,330	40,716	869,949	56.00
60.00	06000	LABORATORY	6,071,022	61,710	92,259	437,986	6,662,977	60.00
65.00	06500	RESPIRATORY THERAPY	1,128,200	22,085	33,018	188,542	1,371,845	65.00
66.00	06600	PHYSICAL THERAPY	2,202,613	90,918	135,928	363,700	2,793,159	66.00
69.00	06900	ELECTROCARDIOLOGY	2,080,677	164,012	245,208	397,216	2,887,113	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	90,314	12,827	19,177	17,778	140,096	69.02
69.03	06903	SLEEP LAB	218,898	18,640	27,867	35,269	300,674	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	4,614,536	0	0	0	4,614,536	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,317,329	0	0	0	9,317,329	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	345,768	21,065	31,494	45,674	444,001	88.00
88.01	08801	RURAL HEALTH CLINIC II	474,129	48,278	72,178	82,826	677,411	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	709,582	60,362	90,245	46,746	906,935	90.00
90.01	09001	IMED	287,005	7,925	11,848	67,569	374,347	90.01
90.02	09002	ONCOLOGY	2,247,010	114,168	170,688	238,597	2,770,463	90.02
90.03	09003	OUTPATIENT CENTER	298,178	0	0	41,222	339,400	90.03
91.00	09100	EMERGENCY	3,152,993	113,527	169,730	1,235,351	4,671,601	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,817,580	20,956	31,330	321,352	2,191,218	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	1,484,291	18,785	28,085	236,764	1,767,925	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	139,764,333	4,163,952	6,225,348	11,332,488	131,088,333	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,846	16,215	0	27,061	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	27,431,674	850,917	1,272,170	4,157,167	33,711,928	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	711,525	27,948	41,785	133,225	914,483	192.01
194.00	07950	LODGE	215	314,630	470,390	14	785,249	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	139,389	5,594	8,363	25,807	179,153	194.02
194.03	07953	MKT/PHY SERVICES	3,369,659	68,382	102,234	309,277	3,849,552	194.03
194.04	07954	COMMUNITY EDUCATION	531,980	63,632	95,134	71,893	762,639	194.04
194.05	07955	VOLUNTEER	164,908	7,102	10,618	29,838	212,466	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	770,800	14,218	21,257	38,604	844,879	194.08
194.09	07959	UNUSED SPACE	0	203,899	304,841	0	508,740	194.09
200.00		Cross Foot Adjustments					0	200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/23/2015 9:52 am

	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	172,884,483	5,731,120	8,568,355	16,098,313	172,884,483	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/23/2015 9:52 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,226,429					5.00
6.00	00600	MAINTENANCE & REPAIRS	1,626,568	10,328,514				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	79,062	53,738	555,771			8.00
9.00	00900	HOUSEKEEPING	274,242	46,286	0	1,787,691		9.00
10.00	01000	DIETARY	140,313	182,605	5,515	31,915	1,111,007	10.00
11.00	01100	CAFETERIA	147,698	36,832	0	6,437	0	11.00
13.00	01300	NURSING ADMINISTRATION	229,795	32,087	0	5,608	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	66,532	31,160	28,782	5,446	0	14.00
15.00	01500	PHARMACY	2,263,897	100,970	0	17,647	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	265,360	84,565	0	14,780	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,132,738	948,598	154,047	165,792	440,388	30.00
31.00	03100	INTENSIVE CARE UNIT	656,780	385,471	49,808	67,371	175,762	31.00
40.00	04000	SUBPROVIDER - IPF	444,818	304,521	20,443	53,223	153,761	40.00
41.00	04100	SUBPROVIDER - IRF	183,388	158,878	11,481	27,768	54,593	41.00
43.00	04300	NURSERY	171,431	119,673	3,625	20,916	82,647	43.00
44.00	04400	SKILLED NURSING FACILITY	321,474	208,853	28,415	36,502	203,856	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	2,016,198	1,035,925	102,991	181,054	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	314,277	219,327	0	38,333	0	52.00
53.00	05300	ANESTHESIOLOGY	182,045	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	840,816	384,934	47,830	67,277	0	54.00
56.00	05600	RADIOISOTOPE	162,611	32,903	0	5,751	0	56.00
60.00	06000	LABORATORY	1,245,444	157,043	1,446	27,447	0	60.00
65.00	06500	RESPIRATORY THERAPY	256,425	56,203	929	9,823	0	65.00
66.00	06600	PHYSICAL THERAPY	522,097	231,375	5,902	40,439	0	66.00
69.00	06900	ELECTROCARDIOLOGY	539,659	417,391	26,484	72,950	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	26,187	32,643	0	5,705	0	69.02
69.03	06903	SLEEP LAB	56,202	47,435	0	8,291	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	862,549	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,741,595	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	82,993	53,608	0	9,369	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	126,622	122,861	0	21,473	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	169,524	153,614	0	26,848	0	90.00
90.01	09001	IMED	69,973	20,168	15	3,525	0	90.01
90.02	09002	ONCOLOGY	517,855	290,545	5,051	50,780	0	90.02
90.03	09003	OUTPATIENT CENTER	63,441	0	0	0	0	90.03
91.00	09100	EMERGENCY	873,216	288,913	61,740	50,495	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	409,582	53,330	0	9,321	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	330,461	47,806	0	8,355	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	19,413,868	6,340,261	554,504	1,090,641	1,111,007	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,058	27,601	0	4,824	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	6,301,459	2,165,482	1,039	378,473	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	170,935	71,125	0	12,431	0	192.01
194.00	07950	LODGE	146,779	800,694	0	139,942	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	33,487	14,236	0	2,488	0	194.02
194.03	07953	MKT/PHY SERVICES	719,558	174,023	0	30,415	0	194.03
194.04	07954	COMMUNITY EDUCATION	142,552	161,937	0	28,303	0	194.04
194.05	07955	VOLUNTEER	39,714	18,073	0	3,159	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	157,925	36,184	0	6,324	0	194.08
194.09	07959	UNUSED SPACE	95,094	518,898	228	90,691	0	194.09
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)	27,226,429	10,328,514	555,771	1,787,691	1,111,007	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/23/2015 9:52 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	981,135					11.00
13.00	01300	NURSING ADMINISTRATION	13,451	1,510,317				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,588	0	495,444			14.00
15.00	01500	PHARMACY	22,766	0	0	14,516,861		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	25,794	0	0	50	1,810,194	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	81,379	531,994	0	2,963	68,719	30.00
31.00	03100	INTENSIVE CARE UNIT	45,983	300,602	0	95	35,425	31.00
40.00	04000	SUBPROVIDER - IPF	34,534	225,760	0	50	24,138	40.00
41.00	04100	SUBPROVIDER - IRF	11,215	73,315	0	0	7,621	41.00
43.00	04300	NURSERY	9,905	64,748	0	0	8,733	43.00
44.00	04400	SKILLED NURSING FACILITY	25,193	0	0	6	7,806	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	65,560	0	0	1,465	311,144	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	18,158	118,706	0	0	20,186	52.00
53.00	05300	ANESTHESIOLOGY	13,787	0	0	1,317	14,028	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,709	0	0	154,507	215,178	54.00
56.00	05600	RADIOISOTOPE	2,657	0	0	0	38,080	56.00
60.00	06000	LABORATORY	49,992	0	0	1,201	160,040	60.00
65.00	06500	RESPIRATORY THERAPY	19,658	0	0	71,665	28,674	65.00
66.00	06600	PHYSICAL THERAPY	31,425	0	0	8,624	36,908	66.00
69.00	06900	ELECTROCARDIOLOGY	28,737	0	0	44,073	120,826	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	1,825	0	0	0	3,066	69.02
69.03	06903	SLEEP LAB	3,814	0	0	0	6,494	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	495,444	0	50,911	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	83,727	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,675,814	345,669	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	3,606	0	0	14,016	3,851	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,267	0	0	17,855	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	5,311	0	0	12,503	14,040	90.00
90.01	09001	IMED	5,556	36,319	0	37,168	2,574	90.01
90.02	09002	ONCOLOGY	24,303	158,873	0	1,081	46,129	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	7	3,445	90.03
91.00	09100	EMERGENCY	53,261	0	0	23,337	111,937	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	40,267	0	0	21,113	21,096	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	22,972	0	0	757	11,739	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	716,673	1,510,317	495,444	14,089,667	1,802,184	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	209,970	0	0	427,194	8,010	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	192.01
194.00	07950	LODGE	20	0	0	0	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	2,397	0	0	0	0	194.02
194.03	07953	MKT/PHY SERVICES	35,520	0	0	0	0	194.03
194.04	07954	COMMUNITY EDUCATION	10,562	0	0	0	0	194.04
194.05	07955	VOLUNTEER	2,230	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	3,763	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
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)	981,135	1,510,317	495,444	14,516,861	1,810,194	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part I Date/Time Prepared: 11/23/2015 9:52 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
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	9,586,634	0	9,586,634	30.00
31.00	03100	INTENSIVE CARE UNIT	5,230,992	0	5,230,992	31.00
40.00	04000	SUBPROVIDER - IPF	3,640,972	0	3,640,972	40.00
41.00	04100	SUBPROVIDER - IRF	1,509,361	0	1,509,361	41.00
43.00	04300	NURSERY	1,398,815	0	1,398,815	43.00
44.00	04400	SKILLED NURSING FACILITY	2,551,955	0	2,551,955	44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	14,500,761	0	14,500,761	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,410,332	0	2,410,332	52.00
53.00	05300	ANESTHESIOLOGY	1,185,095	0	1,185,095	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,250,520	0	6,250,520	54.00
56.00	05600	RADIOISOTOPE	1,111,951	0	1,111,951	56.00
60.00	06000	LABORATORY	8,305,590	0	8,305,590	60.00
65.00	06500	RESPIRATORY THERAPY	1,815,222	0	1,815,222	65.00
66.00	06600	PHYSICAL THERAPY	3,669,929	0	3,669,929	66.00
69.00	06900	ELECTROCARDIOLOGY	4,137,233	0	4,137,233	69.00
69.01	06901	PULMONARY	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	209,522	0	209,522	69.02
69.03	06903	SLEEP LAB	422,910	0	422,910	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,023,440	0	6,023,440	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,142,651	0	11,142,651	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,021,483	0	14,021,483	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	611,444	0	611,444	88.00
88.01	08801	RURAL HEALTH CLINIC II	972,489	0	972,489	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	1,288,775	0	1,288,775	90.00
90.01	09001	IMED	549,645	0	549,645	90.01
90.02	09002	ONCOLOGY	3,865,080	0	3,865,080	90.02
90.03	09003	OUTPATIENT CENTER	406,293	0	406,293	90.03
91.00	09100	EMERGENCY	6,134,500	0	6,134,500	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	2,745,927	0	2,745,927	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,190,015	0	2,190,015	101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	117,889,536	0	117,889,536	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	64,544	0	64,544	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	43,203,555	0	43,203,555	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1,168,974	0	1,168,974	192.01
194.00	07950	LODGE	1,872,684	0	1,872,684	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	231,761	0	231,761	194.02
194.03	07953	MKT/PHY SERVICES	4,809,068	0	4,809,068	194.03
194.04	07954	COMMUNITY EDUCATION	1,105,993	0	1,105,993	194.04
194.05	07955	VOLUNTEER	275,642	0	275,642	194.05
194.06	07956	MAB	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	1,049,075	0	1,049,075	194.08
194.09	07959	UNUSED SPACE	1,213,651	0	1,213,651	194.09
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)	172,884,483	0	172,884,483	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/23/2015 9:52 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	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	32,414	48,460	80,874	80,874	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	1,222,982	1,828,430	3,051,412	7,569	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	417,173	623,698	1,040,871	1,503	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	21,116	31,570	52,686	209	8.00
9.00	00900	HOUSEKEEPING	0	18,188	27,192	45,380	925	9.00
10.00	01000	DIETARY	0	71,754	107,276	179,030	326	10.00
11.00	01100	CAFETERIA	0	14,473	21,638	36,111	671	11.00
13.00	01300	NURSING ADMINISTRATION	0	12,608	18,850	31,458	854	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	12,244	18,306	30,550	219	14.00
15.00	01500	PHARMACY	0	39,676	59,317	98,993	1,718	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33,229	49,680	82,909	998	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	372,748	557,280	930,028	4,078	30.00
31.00	03100	INTENSIVE CARE UNIT	0	151,470	226,456	377,926	2,318	31.00
40.00	04000	SUBPROVIDER - IPF	0	119,661	178,899	298,560	2,019	40.00
41.00	04100	SUBPROVIDER - IRF	0	62,431	93,337	155,768	586	41.00
43.00	04300	NURSERY	0	47,025	70,305	117,330	569	43.00
44.00	04400	SKILLED NURSING FACILITY	0	82,068	122,697	204,765	1,172	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	407,063	608,583	1,015,646	4,239	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	86,184	128,849	215,033	1,042	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	3,126	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	151,258	226,140	377,398	3,701	54.00
56.00	05600	RADIOISOTOPE	0	12,929	19,330	32,259	204	56.00
60.00	06000	LABORATORY	0	61,710	92,259	153,969	2,200	60.00
65.00	06500	RESPIRATORY THERAPY	0	22,085	33,018	55,103	947	65.00
66.00	06600	PHYSICAL THERAPY	0	90,918	135,928	226,846	1,827	66.00
69.00	06900	ELECTROCARDIOLOGY	0	164,012	245,208	409,220	1,995	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	12,827	19,177	32,004	89	69.02
69.03	06903	SLEEP LAB	0	18,640	27,867	46,507	177	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	21,065	31,494	52,559	229	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	48,278	72,178	120,456	416	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	60,362	90,245	150,607	235	90.00
90.01	09001	IMED	0	7,925	11,848	19,773	339	90.01
90.02	09002	ONCOLOGY	0	114,168	170,688	284,856	1,198	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	207	90.03
91.00	09100	EMERGENCY	0	113,527	169,730	283,257	6,204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	20,956	31,330	52,286	1,614	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	0	18,785	28,085	46,870	1,189	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	4,163,952	6,225,348	10,389,300	56,912	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,846	16,215	27,061	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	850,917	1,272,170	2,123,087	20,905	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	27,948	41,785	69,733	669	192.01
194.00	07950	LODGE	0	314,630	470,390	785,020	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	5,594	8,363	13,957	130	194.02
194.03	07953	MKT/PHY SERVICES	0	68,382	102,234	170,616	1,553	194.03
194.04	07954	COMMUNITY EDUCATION	0	63,632	95,134	158,766	361	194.04
194.05	07955	VOLUNTEER	0	7,102	10,618	17,720	150	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	0	14,218	21,257	35,475	194	194.08
194.09	07959	UNUSED SPACE	0	203,899	304,841	508,740	0	194.09
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/23/2015 9:52 am

	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
202.00	TOTAL (sum lines 118-201)	0	5,731,120	8,568,355	14,299,475	80,874	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/23/2015 9:52 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	6.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,058,981					5.00
6.00	00600	MAINTENANCE & REPAIRS	182,750	1,225,124				6.00
8.00	00800	LAUNDRY & LINEN SERVICE	8,883	6,374	68,152			8.00
9.00	00900	HOUSEKEEPING	30,812	5,490	0	82,607		9.00
10.00	01000	DIETARY	15,765	21,660	676	1,475	218,932	10.00
11.00	01100	CAFETERIA	16,594	4,369	0	297	0	11.00
13.00	01300	NURSING ADMINISTRATION	25,818	3,806	0	259	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	7,475	3,696	3,529	252	0	14.00
15.00	01500	PHARMACY	254,355	11,977	0	815	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	29,814	10,031	0	683	0	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	127,266	112,519	18,892	7,661	86,782	30.00
31.00	03100	INTENSIVE CARE UNIT	73,791	45,723	6,108	3,113	34,635	31.00
40.00	04000	SUBPROVIDER - IPF	49,977	36,121	2,507	2,459	30,300	40.00
41.00	04100	SUBPROVIDER - IRF	20,604	18,845	1,408	1,283	10,758	41.00
43.00	04300	NURSERY	19,261	14,195	444	967	16,286	43.00
44.00	04400	SKILLED NURSING FACILITY	36,119	24,773	3,484	1,687	40,171	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	226,526	122,877	12,629	8,366	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,310	26,016	0	1,771	0	52.00
53.00	05300	ANESTHESIOLOGY	20,453	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	94,468	45,659	5,865	3,109	0	54.00
56.00	05600	RADIOISOTOPE	18,270	3,903	0	266	0	56.00
60.00	06000	LABORATORY	139,929	18,628	177	1,268	0	60.00
65.00	06500	RESPIRATORY THERAPY	28,810	6,667	114	454	0	65.00
66.00	06600	PHYSICAL THERAPY	58,659	27,445	724	1,869	0	66.00
69.00	06900	ELECTROCARDIOLOGY	60,632	49,509	3,248	3,371	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	2,942	3,872	0	264	0	69.02
69.03	06903	SLEEP LAB	6,314	5,627	0	383	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	96,910	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	195,673	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	9,324	6,359	0	433	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	14,226	14,573	0	992	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	19,047	18,221	0	1,241	0	90.00
90.01	09001	IMED	7,862	2,392	2	163	0	90.01
90.02	09002	ONCOLOGY	58,182	34,463	619	2,346	0	90.02
90.03	09003	OUTPATIENT CENTER	7,128	0	0	0	0	90.03
91.00	09100	EMERGENCY	98,108	34,270	7,571	2,333	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	46,018	6,326	0	431	0	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	37,128	5,671	0	386	0	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,181,203	752,057	67,997	50,397	218,932	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	568	3,274	0	223	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	708,003	256,856	127	17,489	0	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	19,205	8,437	0	574	0	192.01
194.00	07950	LODGE	16,491	94,975	0	6,467	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	3,762	1,689	0	115	0	194.02
194.03	07953	MKT/PHY SERVICES	80,844	20,642	0	1,405	0	194.03
194.04	07954	COMMUNITY EDUCATION	16,016	19,208	0	1,308	0	194.04
194.05	07955	VOLUNTEER	4,462	2,144	0	146	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	17,743	4,292	0	292	0	194.08
194.09	07959	UNUSED SPACE	10,684	61,550	28	4,191	0	194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,058,981	1,225,124	68,152	82,607	218,932	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II | Date/Time Prepared: 11/23/2015 9:52 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	58,042					11.00
13.00	01300	NURSING ADMINISTRATION	796	62,991				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	449	0	46,170			14.00
15.00	01500	PHARMACY	1,347	0	0	369,205		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,526	0	0	1	125,962	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,814	22,188	0	75	4,780	30.00
31.00	03100	INTENSIVE CARE UNIT	2,720	12,537	0	2	2,464	31.00
40.00	04000	SUBPROVIDER - IPF	2,043	9,416	0	1	1,679	40.00
41.00	04100	SUBPROVIDER - IRF	663	3,058	0	0	530	41.00
43.00	04300	NURSERY	586	2,700	0	0	607	43.00
44.00	04400	SKILLED NURSING FACILITY	1,490	0	0	0	543	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,878	0	0	37	21,642	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,074	4,951	0	0	1,404	52.00
53.00	05300	ANESTHESIOLOGY	816	0	0	33	976	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,467	0	0	3,929	14,967	54.00
56.00	05600	RADIOISOTOPE	157	0	0	0	2,649	56.00
60.00	06000	LABORATORY	2,957	0	0	31	11,132	60.00
65.00	06500	RESPIRATORY THERAPY	1,163	0	0	1,823	1,994	65.00
66.00	06600	PHYSICAL THERAPY	1,859	0	0	219	2,567	66.00
69.00	06900	ELECTROCARDIOLOGY	1,700	0	0	1,121	8,404	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	108	0	0	0	213	69.02
69.03	06903	SLEEP LAB	226	0	0	0	452	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	46,170	0	3,541	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,824	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	347,817	24,094	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	213	0	0	356	268	88.00
88.01	08801	RURAL HEALTH CLINIC II	371	0	0	454	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	314	0	0	318	977	90.00
90.01	09001	IMED	329	1,515	0	945	179	90.01
90.02	09002	ONCOLOGY	1,438	6,626	0	28	3,209	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	240	90.03
91.00	09100	EMERGENCY	3,151	0	0	594	7,786	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,382	0	0	537	1,467	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	1,359	0	0	19	817	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	42,396	62,991	46,170	358,340	125,405	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	12,422	0	0	10,865	557	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0	0	192.01
194.00	07950	LODGE	1	0	0	0	0	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	142	0	0	0	0	194.02
194.03	07953	MKT/PHY SERVICES	2,101	0	0	0	0	194.03
194.04	07954	COMMUNITY EDUCATION	625	0	0	0	0	194.04
194.05	07955	VOLUNTEER	132	0	0	0	0	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	223	0	0	0	0	194.08
194.09	07959	UNUSED SPACE	0	0	0	0	0	194.09
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)	58,042	62,991	46,170	369,205	125,962	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B Part II Date/Time Prepared: 11/23/2015 9:52 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
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
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
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,319,083	0	1,319,083	30.00
31.00	03100	INTENSIVE CARE UNIT	561,337	0	561,337	31.00
40.00	04000	SUBPROVIDER - IPF	435,082	0	435,082	40.00
41.00	04100	SUBPROVIDER - IRF	213,503	0	213,503	41.00
43.00	04300	NURSERY	172,945	0	172,945	43.00
44.00	04400	SKILLED NURSING FACILITY	314,204	0	314,204	44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,415,840	0	1,415,840	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	286,601	0	286,601	52.00
53.00	05300	ANESTHESIOLOGY	25,404	0	25,404	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	551,563	0	551,563	54.00
56.00	05600	RADIOISOTOPE	57,708	0	57,708	56.00
60.00	06000	LABORATORY	330,291	0	330,291	60.00
65.00	06500	RESPIRATORY THERAPY	97,075	0	97,075	65.00
66.00	06600	PHYSICAL THERAPY	322,015	0	322,015	66.00
69.00	06900	ELECTROCARDIOLOGY	539,200	0	539,200	69.00
69.01	06901	PULMONARY	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	39,492	0	39,492	69.02
69.03	06903	SLEEP LAB	59,686	0	59,686	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	146,621	0	146,621	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	201,497	0	201,497	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	371,911	0	371,911	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	69,741	0	69,741	88.00
88.01	08801	RURAL HEALTH CLINIC II	151,488	0	151,488	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	190,960	0	190,960	90.00
90.01	09001	IMED	33,499	0	33,499	90.01
90.02	09002	ONCOLOGY	392,965	0	392,965	90.02
90.03	09003	OUTPATIENT CENTER	7,575	0	7,575	90.03
91.00	09100	EMERGENCY	443,274	0	443,274	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	111,061	0	111,061	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	93,439	0	93,439	101.00
		SPECIAL PURPOSE COST CENTERS				
116.00	11600	HOSPICE	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,955,060	0	8,955,060	118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,126	0	31,126	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	3,150,311	0	3,150,311	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	98,618	0	98,618	192.01
194.00	07950	LODGE	902,954	0	902,954	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	19,795	0	19,795	194.02
194.03	07953	MKT/PHY SERVICES	277,161	0	277,161	194.03
194.04	07954	COMMUNITY EDUCATION	196,284	0	196,284	194.04
194.05	07955	VOLUNTEER	24,754	0	24,754	194.05
194.06	07956	MAB	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	58,219	0	58,219	194.08
194.09	07959	UNUSED SPACE	585,193	0	585,193	194.09
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)	14,299,475	0	14,299,475	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/23/2015 9:52 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	786,816					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		786,816				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,450	4,450	84,656,195			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	167,901	167,901	7,926,121	-27,226,429	145,658,054	5.00
6.00	00600	MAINTENANCE & REPAIRS	57,273	57,273	1,574,224	0	8,701,946	6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,899	2,899	218,809	0	422,971	8.00
9.00	00900	HOUSEKEEPING	2,497	2,497	968,292	0	1,467,163	9.00
10.00	01000	DIETARY	9,851	9,851	340,944	0	750,659	10.00
11.00	01100	CAFETERIA	1,987	1,987	702,997	0	790,168	11.00
13.00	01300	NURSING ADMINISTRATION	1,731	1,731	893,823	0	1,229,376	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	1,681	229,431	0	355,936	14.00
15.00	01500	PHARMACY	5,447	5,447	1,798,688	0	12,111,581	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,562	4,562	1,044,653	0	1,419,645	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,174	51,174	4,270,002	0	6,060,016	30.00
31.00	03100	INTENSIVE CARE UNIT	20,795	20,795	2,427,643	0	3,513,695	31.00
40.00	04000	SUBPROVIDER - IPF	16,428	16,428	2,114,560	0	2,379,724	40.00
41.00	04100	SUBPROVIDER - IRF	8,571	8,571	613,286	0	981,102	41.00
43.00	04300	NURSERY	6,456	6,456	595,293	0	917,137	43.00
44.00	04400	SKILLED NURSING FACILITY	11,267	11,267	1,227,453	0	1,719,850	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,885	55,885	4,438,633	0	10,786,424	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,832	11,832	1,091,371	0	1,681,345	52.00
53.00	05300	ANESTHESIOLOGY	0	0	3,273,303	0	973,918	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,766	20,766	3,875,739	0	4,498,269	54.00
56.00	05600	RADIOISOTOPE	1,775	1,775	214,114	0	869,949	56.00
60.00	06000	LABORATORY	8,472	8,472	2,303,240	0	6,662,977	60.00
65.00	06500	RESPIRATORY THERAPY	3,032	3,032	991,485	0	1,371,845	65.00
66.00	06600	PHYSICAL THERAPY	12,482	12,482	1,912,590	0	2,793,159	66.00
69.00	06900	ELECTROCARDIOLOGY	22,517	22,517	2,088,842	0	2,887,113	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	1,761	1,761	93,488	0	140,096	69.02
69.03	06903	SLEEP LAB	2,559	2,559	185,471	0	300,674	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	4,614,536	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,317,329	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,892	2,892	240,184	0	444,001	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,628	6,628	435,558	0	677,411	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,287	8,287	245,825	0	906,935	90.00
90.01	09001	IMED	1,088	1,088	355,324	0	374,347	90.01
90.02	09002	ONCOLOGY	15,674	15,674	1,254,712	0	2,770,463	90.02
90.03	09003	OUTPATIENT CENTER	0	0	216,775	0	339,400	90.03
91.00	09100	EMERGENCY	15,586	15,586	6,496,345	0	4,671,601	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,877	2,877	1,689,892	0	2,191,218	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,579	2,579	1,245,071	0	1,767,925	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	571,662	571,662	59,594,181	-27,226,429	103,861,904	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,489	1,489	0	0	27,061	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	116,821	116,821	21,861,267	0	33,711,928	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,837	3,837	700,588	0	914,483	192.01
194.00	07950	LODGE	43,195	43,195	72	0	785,249	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	768	768	135,712	0	179,153	194.02
194.03	07953	MKT/PHY SERVICES	9,388	9,388	1,626,393	0	3,849,552	194.03
194.04	07954	COMMUNITY EDUCATION	8,736	8,736	378,064	0	762,639	194.04
194.05	07955	VOLUNTEER	975	975	156,910	0	212,466	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	1,952	1,952	203,008	0	844,879	194.08
194.09	07959	UNUSED SPACE	27,993	27,993	0	0	508,740	194.09
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/23/2015 9:52 am

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,731,120	8,568,355	16,098,313		27,226,429	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	7.283939	10.889909	0.190161		0.186920	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			80,874		3,058,981	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000955		0.021001	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/23/2015 9:52 am

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
			6.00	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
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	557,192					6.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,899	927,509				8.00
9.00	00900	HOUSEKEEPING	2,497	0	551,796			9.00
10.00	01000	DIETARY	9,851	9,203	9,851	27,168		10.00
11.00	01100	CAFETERIA	1,987	0	1,987	0	2,045,375	11.00
13.00	01300	NURSING ADMINISTRATION	1,731	0	1,731	0	28,041	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,681	48,034	1,681	0	15,819	14.00
15.00	01500	PHARMACY	5,447	0	5,447	0	47,460	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,562	0	4,562	0	53,773	16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	51,174	257,084	51,174	10,769	169,651	30.00
31.00	03100	INTENSIVE CARE UNIT	20,795	83,123	20,795	4,298	95,861	31.00
40.00	04000	SUBPROVIDER - IPF	16,428	34,116	16,428	3,760	71,994	40.00
41.00	04100	SUBPROVIDER - IRF	8,571	19,160	8,571	1,335	23,380	41.00
43.00	04300	NURSERY	6,456	6,049	6,456	2,021	20,648	43.00
44.00	04400	SKILLED NURSING FACILITY	11,267	47,421	11,267	4,985	52,519	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	55,885	171,879	55,885	0	136,672	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,832	0	11,832	0	37,855	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	28,742	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,766	79,822	20,766	0	86,951	54.00
56.00	05600	RADIOISOTOPE	1,775	0	1,775	0	5,540	56.00
60.00	06000	LABORATORY	8,472	2,413	8,472	0	104,219	60.00
65.00	06500	RESPIRATORY THERAPY	3,032	1,550	3,032	0	40,981	65.00
66.00	06600	PHYSICAL THERAPY	12,482	9,850	12,482	0	65,511	66.00
69.00	06900	ELECTROCARDIOLOGY	22,517	44,199	22,517	0	59,908	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	1,761	0	1,761	0	3,805	69.02
69.03	06903	SLEEP LAB	2,559	0	2,559	0	7,952	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	2,892	0	2,892	0	7,518	88.00
88.01	08801	RURAL HEALTH CLINIC II	6,628	0	6,628	0	13,064	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,287	0	8,287	0	11,071	90.00
90.01	09001	IMED	1,088	25	1,088	0	11,582	90.01
90.02	09002	ONCOLOGY	15,674	8,430	15,674	0	50,664	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	15,586	103,036	15,586	0	111,034	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,877	0	2,877	0	83,945	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,579	0	2,579	0	47,889	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0	0	116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	342,038	925,394	336,642	27,168	1,494,049	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,489	0	1,489	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	116,821	1,734	116,821	0	437,726	192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3,837	0	3,837	0	0	192.01
194.00	07950	LODGE	43,195	0	43,195	0	42	194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	768	0	768	0	4,998	194.02
194.03	07953	MKT/PHY SERVICES	9,388	0	9,388	0	74,049	194.03
194.04	07954	COMMUNITY EDUCATION	8,736	0	8,736	0	22,018	194.04
194.05	07955	VOLUNTEER	975	0	975	0	4,648	194.05
194.06	07956	MAB	0	0	0	0	0	194.06
194.08	07958	PUBLIC RELATIONS	1,952	0	1,952	0	7,845	194.08
194.09	07959	UNUSED SPACE	27,993	381	27,993	0	0	194.09
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)	10,328,514	555,771	1,787,691	1,111,007	981,135	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/23/2015 9:52 am

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	
		6.00	8.00	9.00	10.00	11.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	18.536723	0.599208	3.239768	40.893956	0.479685	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,225,124	68,152	82,607	218,932	58,042	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.198747	0.073479	0.149706	8.058451	0.028377	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/23/2015 9:52 am

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)		
			13.00	14.00	15.00	16.00		
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
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	481,635					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	100				14.00
15.00	01500	PHARMACY	0	0	10,416,731			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	36	322,826,747		16.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	169,651	0	2,126	12,255,887		30.00
31.00	03100	INTENSIVE CARE UNIT	95,861	0	68	6,317,920		31.00
40.00	04000	SUBPROVIDER - IPF	71,994	0	36	4,304,985		40.00
41.00	04100	SUBPROVIDER - IRF	23,380	0	0	1,359,170		41.00
43.00	04300	NURSERY	20,648	0	0	1,557,555		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	4	1,392,222		44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	1,051	55,492,140		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	37,855	0	0	3,600,165		52.00
53.00	05300	ANESTHESIOLOGY	0	0	945	2,501,876		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	110,868	38,376,746		54.00
56.00	05600	RADIOISOTOPE	0	0	0	6,791,477		56.00
60.00	06000	LABORATORY	0	0	862	28,542,888		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	51,424	5,114,034		65.00
66.00	06600	PHYSICAL THERAPY	0	0	6,188	6,582,440		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	31,625	21,549,215		69.00
69.01	06901	PULMONARY	0	0	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0	0	546,769		69.02
69.03	06903	SLEEP LAB	0	0	0	1,158,141		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	100	0	9,079,968		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,932,609		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	9,813,229	61,630,852		73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	10,057	686,785		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	12,812	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		89.00
90.00	09000	CLINIC	0	0	8,972	2,503,982		90.00
90.01	09001	IMED	11,582	0	26,670	459,075		90.01
90.02	09002	ONCOLOGY	50,664	0	776	8,227,080		90.02
90.03	09003	OUTPATIENT CENTER	0	0	5	614,377		90.03
91.00	09100	EMERGENCY	0	0	16,746	19,963,848		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	15,150	3,762,378		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96.00
101.00	10100	HOME HEALTH AGENCY	0	0	543	2,093,608		101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0	0		116.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	481,635	100	10,110,193	321,398,192		118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	306,538	1,428,555		192.00
192.01	19201	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0	0	0		192.01
194.00	07950	LODGE	0	0	0	0		194.00
194.02	07952	MEMORIAL HOSPITAL FOUNDATION	0	0	0	0		194.02
194.03	07953	MKT/PHY SERVICES	0	0	0	0		194.03
194.04	07954	COMMUNITY EDUCATION	0	0	0	0		194.04
194.05	07955	VOLUNTEER	0	0	0	0		194.05
194.06	07956	MAB	0	0	0	0		194.06
194.08	07958	PUBLIC RELATIONS	0	0	0	0		194.08
194.09	07959	UNUSED SPACE	0	0	0	0		194.09
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet B-1 | Date/Time Prepared: 11/23/2015 9:52 am

	Cost Center Description	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)		
		13.00	14.00	15.00	16.00		
202.00	Cost to be allocated (per Wkst. B, Part I)	1,510,317	495,444	14,516,861	1,810,194		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	3.135812	4,954.440000	1.393610	0.005607		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	62,991	46,170	369,205	125,962		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.130786	461.700000	0.035443	0.000390		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Hospital | PPS

		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	9,586,634		9,586,634	0	9,586,634	30.00
31.00	03100	INTENSIVE CARE UNIT	5,230,992		5,230,992	0	5,230,992	31.00
40.00	04000	SUBPROVIDER - IPF	3,640,972		3,640,972	0	3,640,972	40.00
41.00	04100	SUBPROVIDER - IRF	1,509,361		1,509,361	38,750	1,548,111	41.00
43.00	04300	NURSERY	1,398,815		1,398,815	0	1,398,815	43.00
44.00	04400	SKILLED NURSING FACILITY	2,551,955		2,551,955	0	2,551,955	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,500,761		14,500,761	0	14,500,761	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,410,332		2,410,332	0	2,410,332	52.00
53.00	05300	ANESTHESIOLOGY	1,185,095		1,185,095	0	1,185,095	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,250,520		6,250,520	0	6,250,520	54.00
56.00	05600	RADIOISOTOPE	1,111,951		1,111,951	0	1,111,951	56.00
60.00	06000	LABORATORY	8,305,590		8,305,590	0	8,305,590	60.00
65.00	06500	RESPIRATORY THERAPY	1,815,222	0	1,815,222	0	1,815,222	65.00
66.00	06600	PHYSICAL THERAPY	3,669,929	0	3,669,929	0	3,669,929	66.00
69.00	06900	ELECTROCARDIOLOGY	4,137,233		4,137,233	150,776	4,288,009	69.00
69.01	06901	PULMONARY	0		0	0	0	69.01
69.02	06902	CARDIOPULMONARY	209,522		209,522	0	209,522	69.02
69.03	06903	SLEEP LAB	422,910		422,910	0	422,910	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,023,440		6,023,440	0	6,023,440	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,142,651		11,142,651	0	11,142,651	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,021,483		14,021,483	0	14,021,483	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	611,444		611,444	0	611,444	88.00
88.01	08801	RURAL HEALTH CLINIC II	972,489		972,489	0	972,489	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,288,775		1,288,775	0	1,288,775	90.00
90.01	09001	IMED	549,645		549,645	0	549,645	90.01
90.02	09002	ONCOLOGY	3,865,080		3,865,080	0	3,865,080	90.02
90.03	09003	OUTPATIENT CENTER	406,293		406,293	0	406,293	90.03
91.00	09100	EMERGENCY	6,134,500		6,134,500	7,733	6,142,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,621,934		1,621,934		1,621,934	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,745,927		2,745,927	0	2,745,927	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,190,015		2,190,015		2,190,015	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	119,511,470	0	119,511,470	197,259	119,708,729	200.00
201.00		Less Observation Beds	1,621,934		1,621,934		1,621,934	201.00
202.00		Total (see instructions)	117,889,536	0	117,889,536	197,259	118,086,795	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	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	12,255,887		12,255,887			30.00
31.00	03100	INTENSIVE CARE UNIT	6,317,920		6,317,920			31.00
40.00	04000	SUBPROVIDER - IPF	4,304,985		4,304,985			40.00
41.00	04100	SUBPROVIDER - IRF	1,359,170		1,359,170			41.00
43.00	04300	NURSERY	1,577,555		1,577,555			43.00
44.00	04400	SKILLED NURSING FACILITY	1,392,222		1,392,222			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,248,304	47,243,836	55,492,140	0.261312	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,600,165	0	3,600,165	0.669506	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	812,392	1,689,484	2,501,876	0.473683	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,710,077	33,666,669	38,376,746	0.162873	0.000000	54.00
56.00	05600	RADIOISOTOPE	379,295	6,412,182	6,791,477	0.163727	0.000000	56.00
60.00	06000	LABORATORY	6,472,010	22,070,878	28,542,888	0.290986	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,506,135	2,607,899	5,114,034	0.354949	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,965,421	2,617,019	6,582,440	0.557533	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	6,523,866	15,025,349	21,549,215	0.191990	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0.000000	0.000000	69.01
69.02	06902	CARDIOPULMONARY	987	545,782	546,769	0.383200	0.000000	69.02
69.03	06903	SLEEP LAB	1,700	1,156,441	1,158,141	0.365163	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,551,094	5,528,874	9,079,968	0.663377	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,139,079	5,793,530	14,932,609	0.746196	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,089,818	39,541,034	61,630,852	0.227508	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	686,785	686,785			88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1	1			88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	9,102	2,494,880	2,503,982	0.514690	0.000000	90.00
90.01	09001	IMED	0	459,075	459,075	1.197288	0.000000	90.01
90.02	09002	ONCOLOGY	86,017	8,141,063	8,227,080	0.469800	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	50,000	564,377	614,377	0.661309	0.000000	90.03
91.00	09100	EMERGENCY	3,540,060	16,423,788	19,963,848	0.307280	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	792,000	1,649,344	2,441,344	0.664361	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,100,036	2,662,342	3,762,378	0.729838	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	2,093,608	2,093,608			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	104,785,297	219,074,240	323,859,537			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	104,785,297	219,074,240	323,859,537			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.261312	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.669506	52.00
53.00	05300	ANESTHESIOLOGY	0.473683	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162873	54.00
56.00	05600	RADIOISOTOPE	0.163727	56.00
60.00	06000	LABORATORY	0.290986	60.00
65.00	06500	RESPIRATORY THERAPY	0.354949	65.00
66.00	06600	PHYSICAL THERAPY	0.557533	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198987	69.00
69.01	06901	PULMONARY	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0.383200	69.02
69.03	06903	SLEEP LAB	0.365163	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663377	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.746196	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227508	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC		88.00
88.01	08801	RURAL HEALTH CLINIC II		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		89.00
90.00	09000	CLINIC	0.514690	90.00
90.01	09001	IMED	1.197288	90.01
90.02	09002	ONCOLOGY	0.469800	90.02
90.03	09003	OUTPATIENT CENTER	0.661309	90.03
91.00	09100	EMERGENCY	0.307668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.664361	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.729838	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
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: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I | Date/Time Prepared: 11/23/2015 9:52 am

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	
					Costs			
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,586,634		9,586,634	0	9,586,634	30.00
31.00	03100	INTENSIVE CARE UNIT	5,230,992		5,230,992	0	5,230,992	31.00
40.00	04000	SUBPROVIDER - IPF	3,640,972		3,640,972	0	3,640,972	40.00
41.00	04100	SUBPROVIDER - IRF	1,509,361		1,509,361	38,750	1,548,111	41.00
43.00	04300	NURSERY	1,398,815		1,398,815	0	1,398,815	43.00
44.00	04400	SKILLED NURSING FACILITY	2,551,955		2,551,955	0	2,551,955	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,500,761		14,500,761	0	14,500,761	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,410,332		2,410,332	0	2,410,332	52.00
53.00	05300	ANESTHESIOLOGY	1,185,095		1,185,095	0	1,185,095	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,250,520		6,250,520	0	6,250,520	54.00
56.00	05600	RADIOISOTOPE	1,111,951		1,111,951	0	1,111,951	56.00
60.00	06000	LABORATORY	8,305,590		8,305,590	0	8,305,590	60.00
65.00	06500	RESPIRATORY THERAPY	1,815,222	0	1,815,222	0	1,815,222	65.00
66.00	06600	PHYSICAL THERAPY	3,669,929	0	3,669,929	0	3,669,929	66.00
69.00	06900	ELECTROCARDIOLOGY	4,137,233		4,137,233	150,776	4,288,009	69.00
69.01	06901	PULMONARY	0		0	0	0	69.01
69.02	06902	CARDIOPULMONARY	209,522		209,522	0	209,522	69.02
69.03	06903	SLEEP LAB	422,910		422,910	0	422,910	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,023,440		6,023,440	0	6,023,440	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,142,651		11,142,651	0	11,142,651	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,021,483		14,021,483	0	14,021,483	73.00
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	611,444		611,444	0	611,444	88.00
88.01	08801	RURAL HEALTH CLINIC II	972,489		972,489	0	972,489	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,288,775		1,288,775	0	1,288,775	90.00
90.01	09001	IMED	549,645		549,645	0	549,645	90.01
90.02	09002	ONCOLOGY	3,865,080		3,865,080	0	3,865,080	90.02
90.03	09003	OUTPATIENT CENTER	406,293		406,293	0	406,293	90.03
91.00	09100	EMERGENCY	6,134,500		6,134,500	7,733	6,142,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	1,621,934		1,621,934		1,621,934	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	2,745,927		2,745,927	0	2,745,927	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
101.00	10100	HOME HEALTH AGENCY	2,190,015		2,190,015		2,190,015	101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0		0		0	116.00
200.00		Subtotal (see instructions)	119,511,470	0	119,511,470	197,259	119,708,729	200.00
201.00		Less Observation Beds	1,621,934		1,621,934		1,621,934	201.00
202.00		Total (see instructions)	117,889,536	0	117,889,536	197,259	118,086,795	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I Date/Time Prepared: 11/23/2015 9:52 am

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	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	12,255,887		12,255,887			30.00
31.00	03100	INTENSIVE CARE UNIT	6,317,920		6,317,920			31.00
40.00	04000	SUBPROVIDER - IPF	4,304,985		4,304,985			40.00
41.00	04100	SUBPROVIDER - IRF	1,359,170		1,359,170			41.00
43.00	04300	NURSERY	1,577,555		1,577,555			43.00
44.00	04400	SKILLED NURSING FACILITY	1,392,222		1,392,222			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	8,248,304	47,243,836	55,492,140	0.261312	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,600,165	0	3,600,165	0.669506	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	812,392	1,689,484	2,501,876	0.473683	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,710,077	33,666,669	38,376,746	0.162873	0.000000	54.00
56.00	05600	RADIOISOTOPE	379,295	6,412,182	6,791,477	0.163727	0.000000	56.00
60.00	06000	LABORATORY	6,472,010	22,070,878	28,542,888	0.290986	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	2,506,135	2,607,899	5,114,034	0.354949	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	3,965,421	2,617,019	6,582,440	0.557533	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	6,523,866	15,025,349	21,549,215	0.191990	0.000000	69.00
69.01	06901	PULMONARY	0	0	0	0.000000	0.000000	69.01
69.02	06902	CARDIOPULMONARY	987	545,782	546,769	0.383200	0.000000	69.02
69.03	06903	SLEEP LAB	1,700	1,156,441	1,158,141	0.365163	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,551,094	5,528,874	9,079,968	0.663377	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,139,079	5,793,530	14,932,609	0.746196	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,089,818	39,541,034	61,630,852	0.227508	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	686,785	686,785	0.890299	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1	1	972,489.000000	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	9,102	2,494,880	2,503,982	0.514690	0.000000	90.00
90.01	09001	IMED	0	459,075	459,075	1.197288	0.000000	90.01
90.02	09002	ONCOLOGY	86,017	8,141,063	8,227,080	0.469800	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	50,000	564,377	614,377	0.661309	0.000000	90.03
91.00	09100	EMERGENCY	3,540,060	16,423,788	19,963,848	0.307280	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	792,000	1,649,344	2,441,344	0.664361	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,100,036	2,662,342	3,762,378	0.729838	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY	0	2,093,608	2,093,608			101.00
		SPECIAL PURPOSE COST CENTERS						
116.00	11600	HOSPICE	0	0	0			116.00
200.00		Subtotal (see instructions)	104,785,297	219,074,240	323,859,537			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	104,785,297	219,074,240	323,859,537			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet C Part I | Date/Time Prepared: 11/23/2015 9:52 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
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
56.00	05600	RADIOISOTOPE	0.000000	56.00
60.00	06000	LABORATORY	0.000000	60.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
69.01	06901	PULMONARY	0.000000	69.01
69.02	06902	CARDIOPULMONARY	0.000000	69.02
69.03	06903	SLEEP LAB	0.000000	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0.000000	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	89.00
90.00	09000	CLINIC	0.000000	90.00
90.01	09001	IMED	0.000000	90.01
90.02	09002	ONCOLOGY	0.000000	90.02
90.03	09003	OUTPATIENT CENTER	0.000000	90.03
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS		
95.00	09500	AMBULANCE SERVICES	0.000000	95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	96.00
101.00	10100	HOME HEALTH AGENCY		101.00
		SPECIAL PURPOSE COST CENTERS		
116.00	11600	HOSPICE		116.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part I Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	1,319,083	0	1,319,083	13,092	100.75	30.00
31.00	INTENSIVE CARE UNIT	561,337		561,337	4,298	130.60	31.00
40.00	SUBPROVIDER - IPF	435,082	0	435,082	3,760	115.71	40.00
41.00	SUBPROVIDER - IRF	213,503	0	213,503	1,335	159.93	41.00
43.00	NURSERY	172,945		172,945	2,021	85.57	43.00
44.00	SKILLED NURSING FACILITY	314,204		314,204	4,985	63.03	44.00
200.00	Total (lines 30-199)	3,016,154		3,016,154	29,491		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	5,151	518,963	30.00
31.00	INTENSIVE CARE UNIT	2,812	367,247	31.00
40.00	SUBPROVIDER - IPF	2,232	258,265	40.00
41.00	SUBPROVIDER - IRF	1,011	161,689	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	4,073	256,721	44.00
200.00	Total (lines 30-199)	15,279	1,562,885	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II | Date/Time Prepared: 11/23/2015 9:52 am

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		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	1,415,840	55,492,140	0.025514	4,491,339	114,592	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	286,601	3,600,165	0.079608	0	0	52.00
53.00	05300	ANESTHESIOLOGY	25,404	2,501,876	0.010154	290,386	2,949	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	551,563	38,376,746	0.014372	2,988,177	42,946	54.00
56.00	05600	RADIOISOTOPE	57,708	6,791,477	0.008497	285,805	2,428	56.00
60.00	06000	LABORATORY	330,291	28,542,888	0.011572	3,524,295	40,783	60.00
65.00	06500	RESPIRATORY THERAPY	97,075	5,114,034	0.018982	1,341,355	25,462	65.00
66.00	06600	PHYSICAL THERAPY	322,015	6,582,440	0.048920	1,176,420	57,550	66.00
69.00	06900	ELECTROCARDIOLOGY	539,200	21,549,215	0.025022	3,593,921	89,927	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	39,492	546,769	0.072228	388	28	69.02
69.03	06903	SLEEP LAB	59,686	1,158,141	0.051536	669	34	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	146,621	9,079,968	0.016148	1,874,796	30,274	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	201,497	14,932,609	0.013494	5,199,639	70,164	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	371,911	61,630,852	0.006034	11,225,157	67,733	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	69,741	686,785	0.101547	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	151,488	1	151,488.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	190,960	2,503,982	0.076263	185	14	90.00
90.01	09001	IMED	33,499	459,075	0.072971	0	0	90.01
90.02	09002	ONCOLOGY	392,965	8,227,080	0.047765	6,984	334	90.02
90.03	09003	OUTPATIENT CENTER	7,575	614,377	0.012330	0	0	90.03
91.00	09100	EMERGENCY	443,274	19,963,848	0.022204	2,056,739	45,668	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	223,172	2,441,344	0.091414	247,574	22,632	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	5,957,578	290,795,812		38,303,829	613,518	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part III Date/Time Prepared: 11/23/2015 9:52 am

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		Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0		0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0		0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0		0	44.00
200.00		Total (lines 30-199)	0	0	0		0	200.00

		Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			6.00	7.00	8.00	9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	13,092	0.00	5,151	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,298	0.00	2,812	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,760	0.00	2,232	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,335	0.00	1,011	0	41.00
43.00	04300	NURSERY	2,021	0.00	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	4,985	0.00	4,073	0	44.00
200.00		Total (lines 30-199)	29,491		15,279	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Hospital | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/23/2015 9:52 am

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		Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	55,492,140	0.000000	0.000000	4,491,339	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,600,165	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,501,876	0.000000	0.000000	290,386	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,376,746	0.000000	0.000000	2,988,177	54.00
56.00	05600	RADIOISOTOPE	0	6,791,477	0.000000	0.000000	285,805	56.00
60.00	06000	LABORATORY	0	28,542,888	0.000000	0.000000	3,524,295	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,114,034	0.000000	0.000000	1,341,355	65.00
66.00	06600	PHYSICAL THERAPY	0	6,582,440	0.000000	0.000000	1,176,420	66.00
69.00	06900	ELECTROCARDIOLOGY	0	21,549,215	0.000000	0.000000	3,593,921	69.00
69.01	06901	PULMONARY	0	0	0.000000	0.000000	0	69.01
69.02	06902	CARDIOPULMONARY	0	546,769	0.000000	0.000000	388	69.02
69.03	06903	SLEEP LAB	0	1,158,141	0.000000	0.000000	669	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,079,968	0.000000	0.000000	1,874,796	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,932,609	0.000000	0.000000	5,199,639	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	61,630,852	0.000000	0.000000	11,225,157	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	686,785	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1	0.000000	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	2,503,982	0.000000	0.000000	185	90.00
90.01	09001	IMED	0	459,075	0.000000	0.000000	0	90.01
90.02	09002	ONCOLOGY	0	8,227,080	0.000000	0.000000	6,984	90.02
90.03	09003	OUTPATIENT CENTER	0	614,377	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	19,963,848	0.000000	0.000000	2,056,739	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,441,344	0.000000	0.000000	247,574	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	290,795,812			38,303,829	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV Date/Time Prepared: 11/23/2015 9:52 am

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		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	12,506,785	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	936,586	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	14,648,248	0	54.00
56.00	05600	RADIOISOTOPE	0	2,442,641	0	56.00
60.00	06000	LABORATORY	0	3,494,696	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	73,035	0	65.00
66.00	06600	PHYSICAL THERAPY	0	29,181	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	6,714,189	0	69.00
69.01	06901	PULMONARY	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,717,738	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,908,270	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,153,350	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	1,466,899	0	90.00
90.01	09001	IMED	0	0	0	90.01
90.02	09002	ONCOLOGY	0	869,835	0	90.02
90.03	09003	OUTPATIENT CENTER	0	130,193	0	90.03
91.00	09100	EMERGENCY	0	3,848,292	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	482,267	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00		Total (lines 50-199)	0	71,422,205	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Hospital | PPS

		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	0.261312	12,506,785	0	0	3,268,173	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.669506	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.473683	936,586	0	0	443,645	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162873	14,648,248	0	0	2,385,804	54.00
56.00	05600	RADIOISOTOPE	0.163727	2,442,641	0	0	399,926	56.00
60.00	06000	LABORATORY	0.290986	3,494,696	1,043	0	1,016,908	60.00
65.00	06500	RESPIRATORY THERAPY	0.354949	73,035	0	0	25,924	65.00
66.00	06600	PHYSICAL THERAPY	0.557533	29,181	0	0	16,269	66.00
69.00	06900	ELECTROCARDIOLOGY	0.191990	6,714,189	0	0	1,289,057	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.383200	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.365163	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663377	1,717,738	0	0	1,139,508	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.746196	2,908,270	0	0	2,170,139	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227508	19,153,350	0	98,322	4,357,540	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.514690	1,466,899	0	0	754,998	90.00
90.01	09001	IMED	1.197288	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.469800	869,835	0	0	408,648	90.02
90.03	09003	OUTPATIENT CENTER	0.661309	130,193	0	0	86,098	90.03
91.00	09100	EMERGENCY	0.307280	3,848,292	0	0	1,182,503	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.664361	482,267	0	0	320,399	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.729838		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		71,422,205	1,043	98,322	19,265,539	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		71,422,205	1,043	98,322	19,265,539	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/23/2015 9:52 am

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		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	303	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	PULMONARY	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	69.02
69.03	06903	SLEEP LAB	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	22,369	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	IMED	0	0	90.01
90.02	09002	ONCOLOGY	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	90.03
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	303	22,369	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	303	22,369	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II
Component CCN: 15S115 | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IPF | PPS

		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	1,415,840	55,492,140	0.025514	3,508	90	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	286,601	3,600,165	0.079608	0	0	52.00
53.00	05300	ANESTHESIOLOGY	25,404	2,501,876	0.010154	369	4	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	551,563	38,376,746	0.014372	140,371	2,017	54.00
56.00	05600	RADIOISOTOPE	57,708	6,791,477	0.008497	0	0	56.00
60.00	06000	LABORATORY	330,291	28,542,888	0.011572	257,537	2,980	60.00
65.00	06500	RESPIRATORY THERAPY	97,075	5,114,034	0.018982	12,295	233	65.00
66.00	06600	PHYSICAL THERAPY	322,015	6,582,440	0.048920	31,493	1,541	66.00
69.00	06900	ELECTROCARDIOLOGY	539,200	21,549,215	0.025022	16,628	416	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	39,492	546,769	0.072228	0	0	69.02
69.03	06903	SLEEP LAB	59,686	1,158,141	0.051536	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	146,621	9,079,968	0.016148	12,651	204	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	201,497	14,932,609	0.013494	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	371,911	61,630,852	0.006034	433,852	2,618	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	69,741	686,785	0.101547	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	151,488	1	151,488.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	190,960	2,503,982	0.076263	0	0	90.00
90.01	09001	IMED	33,499	459,075	0.072971	0	0	90.01
90.02	09002	ONCOLOGY	392,965	8,227,080	0.047765	0	0	90.02
90.03	09003	OUTPATIENT CENTER	7,575	614,377	0.012330	0	0	90.03
91.00	09100	EMERGENCY	443,274	19,963,848	0.022204	188,083	4,176	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,441,344	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	5,734,406	290,795,812		1,096,787	14,279	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Component CCN: 15S115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IPF | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 150115 | Component CCN: 15S115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IPF | 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	55,492,140	0.000000	0.000000	3,508	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,600,165	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,501,876	0.000000	0.000000	369	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,376,746	0.000000	0.000000	140,371	54.00
56.00	05600	RADIOISOTOPE	0	6,791,477	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	28,542,888	0.000000	0.000000	257,537	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,114,034	0.000000	0.000000	12,295	65.00
66.00	06600	PHYSICAL THERAPY	0	6,582,440	0.000000	0.000000	31,493	66.00
69.00	06900	ELECTROCARDIOLOGY	0	21,549,215	0.000000	0.000000	16,628	69.00
69.01	06901	PULMONARY	0	0	0.000000	0.000000	0	69.01
69.02	06902	CARDIOPULMONARY	0	546,769	0.000000	0.000000	0	69.02
69.03	06903	SLEEP LAB	0	1,158,141	0.000000	0.000000	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,079,968	0.000000	0.000000	12,651	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,932,609	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	61,630,852	0.000000	0.000000	433,852	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	686,785	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1	0.000000	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	2,503,982	0.000000	0.000000	0	90.00
90.01	09001	IMED	0	459,075	0.000000	0.000000	0	90.01
90.02	09002	ONCOLOGY	0	8,227,080	0.000000	0.000000	0	90.02
90.03	09003	OUTPATIENT CENTER	0	614,377	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	19,963,848	0.000000	0.000000	188,083	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,441,344	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	290,795,812			1,096,787	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Component CCN: 15S115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IPF | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	IMED	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part II
Component CCN: 15T115 | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IRF | PPS

		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	1,415,840	55,492,140	0.025514	5,993	153	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	286,601	3,600,165	0.079608	0	0	52.00
53.00	05300	ANESTHESIOLOGY	25,404	2,501,876	0.010154	903	9	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	551,563	38,376,746	0.014372	24,926	358	54.00
56.00	05600	RADIOISOTOPE	57,708	6,791,477	0.008497	0	0	56.00
60.00	06000	LABORATORY	330,291	28,542,888	0.011572	71,433	827	60.00
65.00	06500	RESPIRATORY THERAPY	97,075	5,114,034	0.018982	44,250	840	65.00
66.00	06600	PHYSICAL THERAPY	322,015	6,582,440	0.048920	671,512	32,850	66.00
69.00	06900	ELECTROCARDIOLOGY	539,200	21,549,215	0.025022	5,122	128	69.00
69.01	06901	PULMONARY	0	0	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	39,492	546,769	0.072228	0	0	69.02
69.03	06903	SLEEP LAB	59,686	1,158,141	0.051536	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	146,621	9,079,968	0.016148	37,833	611	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	201,497	14,932,609	0.013494	356	5	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	371,911	61,630,852	0.006034	370,519	2,236	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	69,741	686,785	0.101547	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	151,488	1	151,488.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	190,960	2,503,982	0.076263	0	0	90.00
90.01	09001	IMED	33,499	459,075	0.072971	0	0	90.01
90.02	09002	ONCOLOGY	392,965	8,227,080	0.047765	0	0	90.02
90.03	09003	OUTPATIENT CENTER	7,575	614,377	0.012330	0	0	90.03
91.00	09100	EMERGENCY	443,274	19,963,848	0.022204	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,441,344	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	5,734,406	290,795,812		1,232,847	38,017	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Component CCN: 15T115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IRF | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV

Component CCN: 15T115 | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IRF | 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	55,492,140	0.000000	0.000000	5,993	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,600,165	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,501,876	0.000000	0.000000	903	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,376,746	0.000000	0.000000	24,926	54.00
56.00	05600	RADIOISOTOPE	0	6,791,477	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	28,542,888	0.000000	0.000000	71,433	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,114,034	0.000000	0.000000	44,250	65.00
66.00	06600	PHYSICAL THERAPY	0	6,582,440	0.000000	0.000000	671,512	66.00
69.00	06900	ELECTROCARDIOLOGY	0	21,549,215	0.000000	0.000000	5,122	69.00
69.01	06901	PULMONARY	0	0	0.000000	0.000000	0	69.01
69.02	06902	CARDIOPULMONARY	0	546,769	0.000000	0.000000	0	69.02
69.03	06903	SLEEP LAB	0	1,158,141	0.000000	0.000000	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,079,968	0.000000	0.000000	37,833	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,932,609	0.000000	0.000000	356	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	61,630,852	0.000000	0.000000	370,519	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	686,785	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1	0.000000	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	2,503,982	0.000000	0.000000	0	90.00
90.01	09001	IMED	0	459,075	0.000000	0.000000	0	90.01
90.02	09002	ONCOLOGY	0	8,227,080	0.000000	0.000000	0	90.02
90.03	09003	OUTPATIENT CENTER	0	614,377	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	19,963,848	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,441,344	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	290,795,812			1,232,847	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Component CCN: 15T115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IRF | 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0	0		56.00
60.00	06000	LABORATORY	0	0	0		60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0		69.00
69.01	06901	PULMONARY	0	0	0		69.01
69.02	06902	CARDIOPULMONARY	0	0	0		69.02
69.03	06903	SLEEP LAB	0	0	0		69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0		88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	0	0		90.00
90.01	09001	IMED	0	0	0		90.01
90.02	09002	ONCOLOGY	0	0	0		90.02
90.03	09003	OUTPATIENT CENTER	0	0	0		90.03
91.00	09100	EMERGENCY	0	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES					95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
200.00		Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Component CCN: 155305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/23/2015 9:52 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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	IMED	0	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
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: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/23/2015 9:52 am

Component CCN: 155305

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	55,492,140	0.000000	0.000000	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,600,165	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,501,876	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	38,376,746	0.000000	0.000000	19,452	54.00
56.00	05600	RADIOISOTOPE	0	6,791,477	0.000000	0.000000	0	56.00
60.00	06000	LABORATORY	0	28,542,888	0.000000	0.000000	261,439	60.00
65.00	06500	RESPIRATORY THERAPY	0	5,114,034	0.000000	0.000000	155,270	65.00
66.00	06600	PHYSICAL THERAPY	0	6,582,440	0.000000	0.000000	1,113,837	66.00
69.00	06900	ELECTROCARDIOLOGY	0	21,549,215	0.000000	0.000000	4,817	69.00
69.01	06901	PULMONARY	0	0	0.000000	0.000000	0	69.01
69.02	06902	CARDIOPULMONARY	0	546,769	0.000000	0.000000	0	69.02
69.03	06903	SLEEP LAB	0	1,158,141	0.000000	0.000000	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,079,968	0.000000	0.000000	130,349	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,932,609	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	61,630,852	0.000000	0.000000	1,442,119	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	686,785	0.000000	0.000000	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	1	0.000000	0.000000	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	2,503,982	0.000000	0.000000	0	90.00
90.01	09001	IMED	0	459,075	0.000000	0.000000	0	90.01
90.02	09002	ONCOLOGY	0	8,227,080	0.000000	0.000000	0	90.02
90.03	09003	OUTPATIENT CENTER	0	614,377	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	19,963,848	0.000000	0.000000	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	2,441,344	0.000000	0.000000	31,434	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES						95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	290,795,812			3,158,717	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 150115 | Component CCN: 155305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part IV | Date/Time Prepared: 11/23/2015 9:52 am

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
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
60.00	06000	LABORATORY	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
69.01	06901	PULMONARY	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	0	69.02
69.03	06903	SLEEP LAB	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	IMED	0	0	0	90.01
90.02	09002	ONCOLOGY	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150115 | Component CCN: 155305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.261312	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.669506	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.473683	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162873	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.163727	0	0	0	0	56.00
60.00	06000	LABORATORY	0.290986	0	0	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.354949	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.557533	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.191990	0	0	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.383200	0	0	0	0	69.02
69.03	06903	SLEEP LAB	0.365163	0	0	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663377	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.746196	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227508	0	0	606	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.514690	0	0	0	0	90.00
90.01	09001	IMED	1.197288	0	0	0	0	90.01
90.02	09002	ONCOLOGY	0.469800	0	0	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.661309	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.307280	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.664361	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.729838		0			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	0	606	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	606	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 150115 | Component CCN: 155305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	56.00
60.00	06000	LABORATORY	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	PULMONARY	0	0	69.01
69.02	06902	CARDIOPULMONARY	0	0	69.02
69.03	06903	SLEEP LAB	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	138	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
90.01	09001	IMED	0	0	90.01
90.02	09002	ONCOLOGY	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	90.03
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	0		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	0	138	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	138	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/23/2015 9:52 am

Title XIX | 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	0.261312	0	5,523,609	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.669506	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.473683	0	192,417	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162873	0	3,221,823	0	0	54.00
56.00	05600	RADIOISOTOPE	0.163727	0	318,277	0	0	56.00
60.00	06000	LABORATORY	0.290986	0	1,840,266	0	0	60.00
65.00	06500	RESPIRATORY THERAPY	0.354949	0	146,489	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.557533	0	285,881	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.191990	0	1,149,789	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.383200	0	9,395	0	0	69.02
69.03	06903	SLEEP LAB	0.365163	0	61,689	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663377	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.746196	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227508	0	1,851,951	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.890299				0	88.00
88.01	08801	RURAL HEALTH CLINIC II	972,489.000000				0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.514690	0	162,833	0	0	90.00
90.01	09001	IMED	1.197288	0	192	0	0	90.01
90.02	09002	ONCOLOGY	0.469800	0	1,243,946	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.661309	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.307280	0	2,794,736	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.664361	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.729838	0	312,222			95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		0	19,115,515	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	19,115,515	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D Part V Date/Time Prepared: 11/23/2015 9:52 am

Title XIX | Hospital | Cost

		Cost Center Description	Costs		
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	1,443,385	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	91,145	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	524,748	0	54.00
56.00	05600	RADIOISOTOPE	52,111	0	56.00
60.00	06000	LABORATORY	535,492	0	60.00
65.00	06500	RESPIRATORY THERAPY	51,996	0	65.00
66.00	06600	PHYSICAL THERAPY	159,388	0	66.00
69.00	06900	ELECTROCARDIOLOGY	220,748	0	69.00
69.01	06901	PULMONARY	0	0	69.01
69.02	06902	CARDIOPULMONARY	3,600	0	69.02
69.03	06903	SLEEP LAB	22,527	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	421,334	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	83,809	0	90.00
90.01	09001	IMED	230	0	90.01
90.02	09002	ONCOLOGY	584,406	0	90.02
90.03	09003	OUTPATIENT CENTER	0	0	90.03
91.00	09100	EMERGENCY	858,766	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
95.00	09500	AMBULANCE SERVICES	227,871		95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00		Subtotal (see instructions)	5,281,556	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	5,281,556	0	202.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Hospital | 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)	13,092	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	13,092	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)	10,877	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)	5,151	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	9,586,634	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)	9,586,634	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)	9,586,634	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)	732.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,771,820	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,771,820	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Hospital | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,230,992	4,298	1,217.08	2,812	3,422,429	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)	13,195,851	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	20,390,100	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)	886,210	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	613,518	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,499,728	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	18,890,372	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	2,215	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	732.25	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	1,621,934	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Hospital | 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	1,319,083	9,586,634	0.137596	1,621,934	223,172	90.00
91.00	Nursing School cost	0	9,586,634	0.000000	1,621,934	0	91.00
92.00	Allied health cost	0	9,586,634	0.000000	1,621,934	0	92.00
93.00	All other Medical Education	0	9,586,634	0.000000	1,621,934	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

	Provider CCN: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1
	Component CCN: 15S115		Date/Time Prepared: 11/23/2015 9:52 am
	Title XVIII	Subprovider - IPF	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)	3,760	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,760	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)	3,760	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)	2,232	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	3,640,972	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)	3,640,972	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3,640,972	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)	968.34	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,161,335	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,161,335	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1

Component CCN: 15S115 | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IPF | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	289,090	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,450,425	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)	258,265	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	14,279	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	272,544	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,177,881	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	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: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1

Component CCN: 15S115 | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IPF | 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	435,082	3,640,972	0.119496	0	0	90.00
91.00	Nursing School cost	0	3,640,972	0.000000	0	0	91.00
92.00	Allied health cost	0	3,640,972	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,640,972	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 150115 Component CCN: 15T115	Period: From 07/01/2014 To 06/30/2015	Worksheet D-1 Date/Time Prepared: 11/23/2015 9:52 am
	Title XVIII	Subprovider - IRF	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)	1,335	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,335	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1,335	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)	1,011	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	1,548,111	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)	1,548,111	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)	1,548,111	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)	1,159.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,172,386	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,172,386	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150115 | Component CCN: 15T115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IRF | 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)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	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)	527,615	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,700,001	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)	161,689	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	38,017	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	199,706	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,500,295	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	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: 150115 | Component CCN: 15T115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IRF | 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	213,503	1,548,111	0.137912	0	0	90.00
91.00	Nursing School cost	0	1,548,111	0.000000	0	0	91.00
92.00	Allied health cost	0	1,548,111	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,548,111	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1

Component CCN: 155305 | Date/Time Prepared: 11/23/2015 9:52 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)	4,985	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4,985	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)	4,985	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)	4,073	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	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	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)	2,551,955	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)	2,551,955	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,551,955	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: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1
Component CCN: 155305 | Date/Time Prepared: 11/23/2015 9:52 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/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	2,551,955	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	511.93	71.00
72.00	Program routine service cost (line 9 x line 71)	2,085,091	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)	2,085,091	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)	2,085,091	83.00
84.00	Program inpatient ancillary services (see instructions)	1,191,731	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)	3,276,822	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: 150115 | Component CCN: 155305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-1 | Date/Time Prepared: 11/23/2015 9:52 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: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Hospital | PPS

		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		5,831,864		30.00
31.00	03100	INTENSIVE CARE UNIT		3,918,560		31.00
40.00	04000	SUBPROVIDER - IPF		5,925		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.261312	4,491,339	1,173,641	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.669506	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.473683	290,386	137,551	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162873	2,988,177	486,693	54.00
56.00	05600	RADIOISOTOPE	0.163727	285,805	46,794	56.00
60.00	06000	LABORATORY	0.290986	3,524,295	1,025,521	60.00
65.00	06500	RESPIRATORY THERAPY	0.354949	1,341,355	476,113	65.00
66.00	06600	PHYSICAL THERAPY	0.557533	1,176,420	655,893	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198987	3,593,921	715,144	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.383200	388	149	69.02
69.03	06903	SLEEP LAB	0.365163	669	244	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663377	1,874,796	1,243,697	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.746196	5,199,639	3,879,950	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227508	11,225,157	2,553,813	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.514690	185	95	90.00
90.01	09001	IMED	1.197288	0	0	90.01
90.02	09002	ONCOLOGY	0.469800	6,984	3,281	90.02
90.03	09003	OUTPATIENT CENTER	0.661309	0	0	90.03
91.00	09100	EMERGENCY	0.307668	2,056,739	632,793	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.664361	247,574	164,479	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		38,303,829	13,195,851	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)		38,303,829		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 150115	Period: From 07/01/2014	Worksheet D-3
	Component CCN: 15S115	To 06/30/2015	Date/Time Prepared: 11/23/2015 9:52 am
	Title XVIII	Subprovider - IPF	PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		2,448,600		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.261312	3,508	917	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.669506	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.473683	369	175	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162873	140,371	22,863	54.00
56.00	05600	RADIOISOTOPE	0.163727	0	0	56.00
60.00	06000	LABORATORY	0.290986	257,537	74,940	60.00
65.00	06500	RESPIRATORY THERAPY	0.354949	12,295	4,364	65.00
66.00	06600	PHYSICAL THERAPY	0.557533	31,493	17,558	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198987	16,628	3,309	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.383200	0	0	69.02
69.03	06903	SLEEP LAB	0.365163	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663377	12,651	8,392	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.746196	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227508	433,852	98,705	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.514690	0	0	90.00
90.01	09001	IMED	1.197288	0	0	90.01
90.02	09002	ONCOLOGY	0.469800	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.661309	0	0	90.03
91.00	09100	EMERGENCY	0.307668	188,083	57,867	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.664361	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		1,096,787	289,090	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,096,787		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3

Component CCN: 15T115 | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		1,025,365		41.00
43.00	04300	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.261312	5,993	1,566	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.669506	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.473683	903	428	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162873	24,926	4,060	54.00
56.00	05600	RADIOISOTOPE	0.163727	0	0	56.00
60.00	06000	LABORATORY	0.290986	71,433	20,786	60.00
65.00	06500	RESPIRATORY THERAPY	0.354949	44,250	15,706	65.00
66.00	06600	PHYSICAL THERAPY	0.557533	671,512	374,390	66.00
69.00	06900	ELECTROCARDIOLOGY	0.198987	5,122	1,019	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.383200	0	0	69.02
69.03	06903	SLEEP LAB	0.365163	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663377	37,833	25,098	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.746196	356	266	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227508	370,519	84,296	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.514690	0	0	90.00
90.01	09001	IMED	1.197288	0	0	90.01
90.02	09002	ONCOLOGY	0.469800	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.661309	0	0	90.03
91.00	09100	EMERGENCY	0.307668	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.664361	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		1,232,847	527,615	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		1,232,847		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3

Component CCN: 155305 | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.261312	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.669506	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.473683	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162873	19,452	3,168	54.00
56.00	05600	RADIOISOTOPE	0.163727	0	0	56.00
60.00	06000	LABORATORY	0.290986	261,439	76,075	60.00
65.00	06500	RESPIRATORY THERAPY	0.354949	155,270	55,113	65.00
66.00	06600	PHYSICAL THERAPY	0.557533	1,113,837	621,001	66.00
69.00	06900	ELECTROCARDIOLOGY	0.191990	4,817	925	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.383200	0	0	69.02
69.03	06903	SLEEP LAB	0.365163	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663377	130,349	86,471	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.746196	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227508	1,442,119	328,094	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
88.01	08801	RURAL HEALTH CLINIC II	0.000000		0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	0.514690	0	0	90.00
90.01	09001	IMED	1.197288	0	0	90.01
90.02	09002	ONCOLOGY	0.469800	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.661309	0	0	90.03
91.00	09100	EMERGENCY	0.307280	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.664361	31,434	20,884	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		3,158,717	1,191,731	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,158,717		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3 | Date/Time Prepared: 11/23/2015 9:52 am

Title XIX | Hospital | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		2,327,973		30.00
31.00	03100	INTENSIVE CARE UNIT		285,598		31.00
40.00	04000	SUBPROVIDER - IPF		96,893		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		280,853		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.261312	452,697	118,295	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.669506	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.473683	99,333	47,052	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162873	325,169	52,961	54.00
56.00	05600	RADIOISOTOPE	0.163727	21,255	3,480	56.00
60.00	06000	LABORATORY	0.290986	516,695	150,351	60.00
65.00	06500	RESPIRATORY THERAPY	0.354949	137,531	48,816	65.00
66.00	06600	PHYSICAL THERAPY	0.557533	32,210	17,958	66.00
69.00	06900	ELECTROCARDIOLOGY	0.191990	326,071	62,602	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.383200	0	0	69.02
69.03	06903	SLEEP LAB	0.365163	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663377	85	56	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.746196	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227508	1,414,241	321,751	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.890299	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	972,489.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.514690	0	0	90.00
90.01	09001	IMED	1.197288	0	0	90.01
90.02	09002	ONCOLOGY	0.469800	18,804	8,834	90.02
90.03	09003	OUTPATIENT CENTER	0.661309	4,832	3,195	90.03
91.00	09100	EMERGENCY	0.307280	271,929	83,558	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.664361	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		3,620,852	918,909	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net Charges (line 200 minus line 201)		3,620,852		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3

Component CCN: 15S115 | Date/Time Prepared: 11/23/2015 9:52 am

Title XIX | Subprovider - IPF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		483,880		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.261312	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.669506	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.473683	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162873	706	115	54.00
56.00	05600	RADIOISOTOPE	0.163727	0	0	56.00
60.00	06000	LABORATORY	0.290986	109,682	31,916	60.00
65.00	06500	RESPIRATORY THERAPY	0.354949	5,267	1,870	65.00
66.00	06600	PHYSICAL THERAPY	0.557533	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.191990	5,670	1,089	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.383200	0	0	69.02
69.03	06903	SLEEP LAB	0.365163	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663377	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.746196	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227508	79,991	18,199	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.890299	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	972,489.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.514690	0	0	90.00
90.01	09001	IMED	1.197288	0	0	90.01
90.02	09002	ONCOLOGY	0.469800	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.661309	0	0	90.03
91.00	09100	EMERGENCY	0.307280	144,715	44,468	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.664361	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		346,031	97,657	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)		346,031		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet D-3

Component CCN: 15T115 | Date/Time Prepared: 11/23/2015 9:52 am

Title XIX | Subprovider - IRF | Cost

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		7,105		41.00
43.00	04300	NURSERY		0		43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.261312	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.669506	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.473683	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.162873	0	0	54.00
56.00	05600	RADIOISOTOPE	0.163727	0	0	56.00
60.00	06000	LABORATORY	0.290986	187	54	60.00
65.00	06500	RESPIRATORY THERAPY	0.354949	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.557533	5,881	3,279	66.00
69.00	06900	ELECTROCARDIOLOGY	0.191990	0	0	69.00
69.01	06901	PULMONARY	0.000000	0	0	69.01
69.02	06902	CARDIOPULMONARY	0.383200	0	0	69.02
69.03	06903	SLEEP LAB	0.365163	0	0	69.03
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.663377	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.746196	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.227508	1,280	291	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.890299	0	0	88.00
88.01	08801	RURAL HEALTH CLINIC II	972,489.000000	0	0	88.01
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89.00
90.00	09000	CLINIC	0.514690	0	0	90.00
90.01	09001	IMED	1.197288	0	0	90.01
90.02	09002	ONCOLOGY	0.469800	0	0	90.02
90.03	09003	OUTPATIENT CENTER	0.661309	0	0	90.03
91.00	09100	EMERGENCY	0.307280	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.664361	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES				95.00
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00		Total (sum of lines 50-94 and 96-98)		7,348	3,624	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)		7,348		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Date/Time Prepared: 11/23/2015 9:52 am

		Title XVIII		Hospital	PPS	
			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0			1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		4,652,967			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		13,958,900			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0			1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0			1.04
2.00	Outlier payments for discharges. (see instructions)		63,436			2.00
2.01	Outlier reconciliation amount		0			2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0			2.02
3.00	Managed Care Simulated Payments		0			3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		104.93			4.00
	Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00			5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00			6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00			7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00			7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00			8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00			8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00			8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)		0.00			9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00			10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00			11.00
12.00	Current year allowable FTE (see instructions)		0.00			12.00
13.00	Total allowable FTE count for the prior year.		0.00			13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00			14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00			15.00
16.00	Adjustment for residents in initial years of the program		0.00			16.00
17.00	Adjusment for residents displaced by program or hospital closure		0.00			17.00
18.00	Adjusted rolling average FTE count		0.00			18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000			19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000			20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000			21.00
22.00	IME payment adjustment (see instructions)		0			22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0			22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00			23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00			24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00			25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000			26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000			27.00
28.00	IME add-on adjustment amount (see instructions)		0			28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0			28.01
29.00	Total IME payment (sum of lines 22 and 28)		0			29.00

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			before 1/1	on/after 1/1		
		0	1.00	1.01	2.00	
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0			29.01
	Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.82			30.00
31.00	Percentage of Medicaid patient days (see instructions)		14.67			31.00
32.00	Sum of lines 30 and 31		17.49			32.00
33.00	Allowable disproportionate share percentage (see instructions)		4.12			33.00
34.00	Disproportionate share adjustment (see instructions)		191,703			34.00
			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
	Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		9,046,380,143		7,647,644,885	35.00
35.01	Factor 3 (see instructions)		0.000008608		0.000083679	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		778,744		639,948	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		196,286		478,646	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		674,932			36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0			40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0			46.00
47.00	Subtotal (see instructions)		19,541,938			47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)		0			48.00
49.00	Total payment for inpatient operating costs (see instructions)		19,541,938			49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,471,303			50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0			51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0			52.00
53.00	Nursing and Allied Health Managed Care payment		0			53.00
54.00	Special add-on payments for new technologies		0			54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0			55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0			56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0			57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0			58.00
59.00	Total (sum of amounts on lines 49 through 58)		21,013,241			59.00
60.00	Primary payer payments		26,246			60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		20,986,995			61.00
62.00	Deductibles billed to program beneficiaries		2,300,644			62.00

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			Prior to October 1		On/After October 1	
		0	1.00	1.01	2.00	
63.00	Coinsurance billed to program beneficiaries		1,216			63.00
64.00	Allowable bad debts (see instructions)		63,996			64.00
65.00	Adjusted reimbursable bad debts (see instructions)		41,597			65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		8,588			66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		18,726,732			67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0			68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0			69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0			70.00
70.50	RURAL DEMONSTRATION PROJECT		0			70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0			70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0			70.91
70.92	Bundled Model 1 discount amount (see instructions)		0			70.92
70.93	HVBP payment adjustment amount (see instructions)		105,362			70.93
70.94	HRR adjustment amount (see instructions)		0			70.94
70.95	Recovery of accelerated depreciation		0			70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0			70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0			70.97
70.98	Low Volume Payment-3		0			70.98
70.99	HAC adjustment amount (see instructions)		162,214			70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		18,669,880			71.00
71.01	Sequestration adjustment (see instructions)		373,398			71.01
72.00	Interim payments		18,199,411			72.00
73.00	Tentative settlement (for contractor use only)		0			73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		97,071			74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		63,653			75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0			90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0			91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0			92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0			93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00			94.00
95.00	Time value of money for operating expenses (see instructions)		0			95.00
96.00	Time value of money for capital related expenses (see instructions)		0			96.00

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		Prior to 10/1		On/After 10/1	
		1.00	1.01	2.00	
	HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)	0		0	100.00
	HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0		0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0		0	102.00
	HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0		0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,652,967	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13,958,900	0	0	18,611,867	18,611,867	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	63,436	0	0	63,436	63,436	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0412	0.0412	0.0412	0.0412		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	191,703	0	0	191,703	191,703	11.00
11.01	Uncompensated care payments	36.00	674,932	0	196,286	478,646	674,932	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	19,541,938	0	196,286	19,345,652	19,541,938	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	19,541,938	0	196,286	19,345,652	19,541,938	15.00
16.00	Payment for inpatient program capital	50.00	1,471,303	0	0	1,471,303	1,471,303	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	196,286	20,816,955	21,013,241	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	1,467,580	0	0	1,467,580	1,467,580	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	3,723	0	0	3,723	3,723	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,471,303	0	0	1,471,303	1,471,303	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/23/2015 9:52 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	4,652,967	4,652,967		4,652,967	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	13,958,900		13,958,900	13,958,900	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	63,436	0	63,436	63,436	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0412	0.0412	0.0412		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	191,703	47,926	143,777	191,703	11.00
11.01	Uncompensated care payments	36.00	674,932	196,286	478,646	674,932	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	19,541,938	4,897,179	14,644,759	19,541,938	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	19,541,938	4,897,179	14,644,759	19,541,938	15.00
16.00	Payment for inpatient program capital	50.00	1,471,303	0	1,471,303	1,471,303	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			4,897,179	16,116,062	21,013,241	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/23/2015 9:52 am
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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,467,580	0	1,467,580	1,467,580	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	3,723	0	3,723	3,723	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,471,303	0	1,471,303	1,471,303	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	105,362	0	105,362	105,362	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	0	0	0	0	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	162,214	162,214	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part B Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Hospital | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	22,672	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	19,265,539	2.00
3.00	PPS payments	20,774,770	3.00
4.00	Outlier payment (see instructions)	23,048	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)	22,672	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	99,365	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	99,365	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)	99,365	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	76,693	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)	22,672	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)	20,797,818	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4,309,820	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	16,510,670	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)	16,510,670	30.00
31.00	Primary payer payments	12,437	31.00
32.00	Subtotal (line 30 minus line 31)	16,498,233	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)	341,774	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	222,153	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	263,997	36.00
37.00	Subtotal (see instructions)	16,720,386	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-366	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)	16,720,752	40.00
40.01	Sequestration adjustment (see instructions)	334,415	40.01
41.00	Interim payments	16,338,843	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	47,494	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

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 150115 | Component CCN: 155305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E Part B | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Skilled Nursing Facility | PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	138	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	PPS payments		3.00
4.00	Outlier payment (see instructions)		4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		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)	138	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	606	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	606	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)	606	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	468	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)	138	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)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	138	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)	138	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	138	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)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	138	37.00
38.00	MSP-LCC reconciliation amount from PS&R		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)	138	40.00
40.01	Sequestration adjustment (see instructions)	3	40.01
41.00	Interim payments	131	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	4	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)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Hospital | PPS

		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		18,199,411		16,338,843	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		18,199,411		16,338,843	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		97,071		47,494	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		18,296,482		16,386,337	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: 150115 | Component CCN: 15S115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,870,816		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,870,816		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		6,867		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,877,683		0	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: 150115 | Component CCN: 15T115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,471,732		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,471,732		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		11,378		0	6.02
7.00	Total Medicare program liability (see instructions)		1,460,354		0	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: 150115 | Component CCN: 155305 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-1 Part I | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,300,449		131	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,300,449		131	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		5,648		4	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,306,097		135	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: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet E-1 Part II Date/Time Prepared: 11/23/2015 9:52 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	5,941	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	7,963	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	365	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	15,175	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	323,859,537	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	3,216,273	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)	1,229,881	8.00
9.00	Sequestration adjustment amount (see instructions)	24,598	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	1,205,283	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	1,187,998	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)	17,285	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 150115 | Component CCN: 15S115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-3 Part II | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IPF | PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2,113,011	1.00
2.00	Net IPF PPS Outlier Payments	22,989	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	10.301370	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	2,136,000	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	2,136,000	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	2,136,000	18.00
19.00	Deductibles	197,860	19.00
20.00	Subtotal (line 18 minus line 19)	1,938,140	20.00
21.00	Coinsurance	29,115	21.00
22.00	Subtotal (line 20 minus line 21)	1,909,025	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	10,736	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	6,978	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	8,304	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,916,003	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,916,003	31.00
31.01	Sequestration adjustment (see instructions)	38,320	31.01
32.00	Interim payments	1,870,816	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	6,867	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	22,989	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 150115 | Component CCN: 15T115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet E-3 Part III | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Subprovider - IRF | PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	1,483,767	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0064	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	8,309	3.00
4.00	Outlier Payments	23,280	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	3.657534	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	1,515,356	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	1,515,356	17.00
18.00	Primary payer payments	7,695	18.00
19.00	Subtotal (line 17 less line 18).	1,507,661	19.00
20.00	Deductibles	14,768	20.00
21.00	Subtotal (line 19 minus line 20)	1,492,893	21.00
22.00	Coinsurance	2,736	22.00
23.00	Subtotal (line 21 minus line 22)	1,490,157	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	0	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	1,490,157	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	1,490,157	32.00
32.01	Sequestration adjustment (see instructions)	29,803	32.01
33.00	Interim payments	1,471,732	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33, and 34)	-11,378	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	23,280	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150115 Component CCN: 155305	Period: From 07/01/2014 To 06/30/2015	Worksheet E-3 Part VI Date/Time Prepared: 11/23/2015 9:52 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)	1,506,628	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)	1,506,628	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	179,639	7.00
8.00	Allowable bad debts (see instructions)	7,947	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	5,427	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	5,763	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)	1,332,752	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	1,332,752	15.00
15.01	Sequestration adjustment (see instructions)	26,655	15.01
16.00	Interim payments	1,300,449	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)	5,648	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: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G | Date/Time Prepared: 11/23/2015 9:52 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	56,390,183	0	0	0	1.00
2.00	Temporary investments	938,519	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	24,785,862	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	7,831,992	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)	89,946,556	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	7,585,948	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	109,931,972	0	0	0	15.00
16.00	Accumulated depreciation	-56,995,535	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	95,665,287	0	0	0	19.00
20.00	Accumulated depreciation	-61,201,729	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	94,985,943	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	62,013,741	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	2,474,788	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	64,488,529	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	249,421,028	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	4,465,543	0	0	0	37.00
38.00	Salaries, wages, and fees payable	14,695,013	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	1,615,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	3,767,400				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	0	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	24,542,956	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	55,047,095	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	55,047,095	0	0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	79,590,051	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	169,830,977				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)	169,830,977	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	249,421,028	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-1 | Date/Time Prepared: 11/23/2015 9:52 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		165,358,962		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,032,110				2.00
3.00	Total (sum of line 1 and line 2)		170,391,072		0		3.00
4.00	FOUNDATION EXPENSE	-1,156,454		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)		-1,156,454		0		10.00
11.00	Subtotal (line 3 plus line 10)		169,234,618		0		11.00
12.00	NET ASSETS RELEASED	-596,359		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)		-596,359		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		169,830,977		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	FOUNDATION EXPENSE		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	NET ASSETS RELEASED		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: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet G-2 Parts I & II Date/Time Prepared: 11/23/2015 9:52 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	19,452,714		19,452,714	1.00
2.00	SUBPROVIDER - IPF	4,376,952		4,376,952	2.00
3.00	SUBPROVIDER - IRF	1,359,170		1,359,170	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,465,117		1,465,117	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)	26,653,953		26,653,953	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	6,898,676		6,898,676	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)	6,898,676		6,898,676	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	33,552,629		33,552,629	17.00
18.00	Ancillary services	81,843,052	248,780,901	330,623,953	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	686,785	686,785	20.00
20.01	RURAL HEALTH CLINIC II	0	0	0	20.01
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		2,093,608	2,093,608	22.00
23.00	AMBULANCE SERVICES	1,100,036	2,662,342	3,762,378	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	PHYSICIANS	0	46,733,172	46,733,172	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	116,495,717	300,956,808	417,452,525	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		190,899,121		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		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)		190,899,121		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 150115	Period: From 07/01/2014 To 06/30/2015	Worksheet G-3 Date/Time Prepared: 11/23/2015 9:52 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	417,452,525	1.00
2.00	Less contractual allowances and discounts on patients' accounts	227,229,497	2.00
3.00	Net patient revenues (line 1 minus line 2)	190,223,028	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	190,899,121	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-676,093	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	227,870	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	599,395	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	214,810	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	406	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISCELLANEOUS	4,665,722	24.00
25.00	Total other income (sum of lines 6-24)	5,708,203	25.00
26.00	Total (line 5 plus line 25)	5,032,110	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,032,110	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 150115 | HHA CCN: 157222 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H | Date/Time Prepared: 11/23/2015 9:52 am

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	343,408	0	0	53,263	87,234	483,905	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	583,226	0	61,223	0	0	644,449	6.00
7.00	Physical Therapy	83,162	0	24,514	0	0	107,676	7.00
8.00	Occupational Therapy	58,606	0	7,753	0	0	66,359	8.00
9.00	Speech Pathology	6,358	0	603	0	0	6,961	9.00
10.00	Medical Social Services	204	0	8	0	0	212	10.00
11.00	Home Health Aide	156,917	0	34,249	0	0	191,166	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,231,881	0	128,350	53,263	87,234	1,500,728	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
		7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0	1.00
2.00	Capital Related - Movable Equipment	0	0	0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	4.00
5.00	Administrative and General	-16,437	467,468	0	467,468	5.00
	HHA REIMBURSABLE SERVICES					
6.00	Skilled Nursing Care	0	644,449	0	644,449	6.00
7.00	Physical Therapy	0	107,676	0	107,676	7.00
8.00	Occupational Therapy	0	66,359	0	66,359	8.00
9.00	Speech Pathology	0	6,961	0	6,961	9.00
10.00	Medical Social Services	0	212	0	212	10.00
11.00	Home Health Aide	0	191,166	0	191,166	11.00
12.00	Supplies (see instructions)	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	13.00
14.00	DME	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES					
15.00	Home Dialysis Aide Services	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	-16,437	1,484,291	0	1,484,291	24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 150115 | HHA CCN: 157222 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-1 Part I | Date/Time Prepared: 11/23/2015 9:52 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	467,468	0	0	0	0	467,468	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	644,449	0	0	0	0	644,449	6.00
7.00	Physical Therapy	107,676	0	0	0	0	107,676	7.00
8.00	Occupational Therapy	66,359	0	0	0	0	66,359	8.00
9.00	Speech Pathology	6,961	0	0	0	0	6,961	9.00
10.00	Medical Social Services	212	0	0	0	0	212	10.00
11.00	Home Health Aide	191,166	0	0	0	0	191,166	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,484,291	0	0	0	0	1,484,291	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	467,468		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	296,276	940,725	6.00
7.00	Physical Therapy	49,502	157,178	7.00
8.00	Occupational Therapy	30,507	96,866	8.00
9.00	Speech Pathology	3,200	10,161	9.00
10.00	Medical Social Services	97	309	10.00
11.00	Home Health Aide	87,886	279,052	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
24.00	Total (sum of lines 1-23)		1,484,291	24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 150115 | HHA CCN: 157222 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-1 Part II | Date/Time Prepared: 11/23/2015 9:52 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-467,468	1,016,823	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	644,449	6.00
7.00	Physical Therapy	0	0	0	0	0	107,676	7.00
8.00	Occupational Therapy	0	0	0	0	0	66,359	8.00
9.00	Speech Pathology	0	0	0	0	0	6,961	9.00
10.00	Medical Social Services	0	0	0	0	0	212	10.00
11.00	Home Health Aide	0	0	0	0	0	191,166	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-467,468	1,016,823	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		467,468	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.459734	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS	Provider CCN: 150115 HHA CCN: 157222	Period: From 07/01/2014 To 06/30/2015	Worksheet H-2 Part I Date/Time Prepared: 11/23/2015 9:52 am
		Home Health Agency I	PPS

	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	18,785	28,085	66,002	112,872	21,098	1.00
2.00	Skilled Nursing Care	940,725	0	0	112,094	1,052,819	196,793	2.00
3.00	Physical Therapy	157,178	0	0	15,984	173,162	32,367	3.00
4.00	Occupational Therapy	96,866	0	0	11,264	108,130	20,212	4.00
5.00	Speech Pathology	10,161	0	0	1,222	11,383	2,128	5.00
6.00	Medical Social Services	309	0	0	39	348	65	6.00
7.00	Home Health Aide	279,052	0	0	30,159	309,211	57,798	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	1,484,291	18,785	28,085	236,764	1,767,925	330,461	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	MAINTENANCE & REPAIRS	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		6.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	47,806	0	8,355	0	5,845	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	10,268	0	2.00
3.00	Physical Therapy	0	0	0	0	1,784	0	3.00
4.00	Occupational Therapy	0	0	0	0	809	0	4.00
5.00	Speech Pathology	0	0	0	0	88	0	5.00
6.00	Medical Social Services	0	0	0	0	4	0	6.00
7.00	Home Health Aide	0	0	0	0	4,174	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	47,806	0	8,355	0	22,972	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 150115 | HHA CCN: 157222 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-2 Part I | Date/Time Prepared: 11/23/2015 9:52 am

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	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
		14.00	15.00	16.00	24.00	25.00	26.00	
1.00	Administrative and General	0	757	0	196,733	0	196,733	1.00
2.00	Skilled Nursing Care	0	0	5,600	1,265,480	0	1,265,480	2.00
3.00	Physical Therapy	0	0	2,242	209,555	0	209,555	3.00
4.00	Occupational Therapy	0	0	709	129,860	0	129,860	4.00
5.00	Speech Pathology	0	0	55	13,654	0	13,654	5.00
6.00	Medical Social Services	0	0	1	418	0	418	6.00
7.00	Home Health Aide	0	0	3,132	374,315	0	374,315	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	757	11,739	2,190,015	0	2,190,015	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	124,900	1,390,380	2.00
3.00	Physical Therapy	20,683	230,238	3.00
4.00	Occupational Therapy	12,817	142,677	4.00
5.00	Speech Pathology	1,348	15,002	5.00
6.00	Medical Social Services	41	459	6.00
7.00	Home Health Aide	36,944	411,259	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	196,733	2,190,015	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.	0.098698		21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150115 | HHA CCN: 157222 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-2 Part II | Date/Time Prepared: 11/23/2015 9:52 am

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	Cost Center Description	CAPITAL RELATED COSTS						
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	6.00	
1.00	Administrative and General	2,579	2,579	347,085	0	112,872	2,579	1.00
2.00	Skilled Nursing Care	0	0	589,471	0	1,052,819	0	2.00
3.00	Physical Therapy	0	0	84,053	0	173,162	0	3.00
4.00	Occupational Therapy	0	0	59,233	0	108,130	0	4.00
5.00	Speech Pathology	0	0	6,426	0	11,383	0	5.00
6.00	Medical Social Services	0	0	206	0	348	0	6.00
7.00	Home Health Aide	0	0	158,597	0	309,211	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	2,579	2,579	1,245,071		1,767,925	2,579	20.00
21.00	Total cost to be allocated	18,785	28,085	236,764		330,461	47,806	21.00
22.00	Unit cost multiplier	7.283831	10.889880	0.190161		0.186920	18.536642	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (PATIENT DAYS)	CAFETERIA (HOURS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	2,579	0	12,185	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	21,405	0	0	2.00
3.00	Physical Therapy	0	0	0	3,719	0	0	3.00
4.00	Occupational Therapy	0	0	0	1,686	0	0	4.00
5.00	Speech Pathology	0	0	0	184	0	0	5.00
6.00	Medical Social Services	0	0	0	9	0	0	6.00
7.00	Home Health Aide	0	0	0	8,701	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19)	0	2,579	0	47,889	0	0	20.00
21.00	Total cost to be allocated	0	8,355	0	22,972	0	0	21.00
22.00	Unit cost multiplier	0.000000	3.239628	0.000000	0.479693	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 150115 | HHA CCN: 157222 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-2 Part II | Date/Time Prepared: 11/23/2015 9:52 am

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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (REVENUE)	
		15.00	16.00	
1.00	Administrative and General	543	0	1.00
2.00	Skilled Nursing Care	0	998,655	2.00
3.00	Physical Therapy	0	399,866	3.00
4.00	Occupational Therapy	0	126,465	4.00
5.00	Speech Pathology	0	9,832	5.00
6.00	Medical Social Services	0	135	6.00
7.00	Home Health Aide	0	558,655	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
20.00	Total (sum of lines 1-19)	543	2,093,608	20.00
21.00	Total cost to be allocated	757	11,739	21.00
22.00	Unit cost multiplier	1.394107	0.005607	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150115 | HHA CCN: 157222 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-3 Part I | Date/Time Prepared: 11/23/2015 9:52 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	1,390,380		1,390,380	7,415	187.51	1.00
2.00	Physical Therapy	3.00	230,238	0	230,238	2,969	77.55	2.00
3.00	Occupational Therapy	4.00	142,677	0	142,677	939	151.95	3.00
4.00	Speech Pathology	5.00	15,002	0	15,002	73	205.51	4.00
5.00	Medical Social Services	6.00	459		459	1	459.00	5.00
6.00	Home Health Aide	7.00	411,259		411,259	4,148	99.15	6.00
7.00	Total (sum of lines 1-6)		2,190,015	0	2,190,015	15,545		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits				
				Part A	Part B			
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		99915	0	4,882			8.00
8.01	Skilled Nursing Care		50031	0	0			8.01
9.00	Physical Therapy		99915	0	2,205			9.00
9.01	Physical Therapy		50031	0	0			9.01
10.00	Occupational Therapy		99915	0	687			10.00
10.01	Occupational Therapy		50031	0	0			10.01
11.00	Speech Pathology		99915	0	25			11.00
11.01	Speech Pathology		50031	0	0			11.01
12.00	Medical Social Services		99915	0	1			12.00
12.01	Medical Social Services		50031	0	0			12.01
13.00	Home Health Aide		99915	0	2,042			13.00
13.01	Home Health Aide		50031	0	0			13.01
14.00	Total (sum of lines 8-13)			0	9,842			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	62,002	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits			Cost of Services			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	4,882		0	915,424		1.00
2.00	Physical Therapy	0	2,205		0	170,998		2.00
3.00	Occupational Therapy	0	687		0	104,390		3.00
4.00	Speech Pathology	0	25		0	5,138		4.00
5.00	Medical Social Services	0	1		0	459		5.00
6.00	Home Health Aide	0	2,042		0	202,464		6.00
7.00	Total (sum of lines 1-6)	0	9,842		0	1,398,873		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150115 | HHA CCN: 157222 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-3 Part I | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
8.01	Skilled Nursing Care							8.01
9.00	Physical Therapy							9.00
9.01	Physical Therapy							9.01
10.00	Occupational Therapy							10.00
10.01	Occupational Therapy							10.01
11.00	Speech Pathology							11.00
11.01	Speech Pathology							11.01
12.00	Medical Social Services							12.00
12.01	Medical Social Services							12.01
13.00	Home Health Aide							13.00
13.01	Home Health Aide							13.01
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		3,746	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	915,424	1.00
2.00	Physical Therapy	170,998	2.00
3.00	Occupational Therapy	104,390	3.00
4.00	Speech Pathology	5,138	4.00
5.00	Medical Social Services	459	5.00
6.00	Home Health Aide	202,464	6.00
7.00	Total (sum of lines 1-6)	1,398,873	7.00

	Cost Center Description		
		12.00	
	Limitation Cost Computation		
8.00	Skilled Nursing Care		8.00
8.01	Skilled Nursing Care		8.01
9.00	Physical Therapy		9.00
9.01	Physical Therapy		9.01
10.00	Occupational Therapy		10.00
10.01	Occupational Therapy		10.01
11.00	Speech Pathology		11.00
11.01	Speech Pathology		11.01
12.00	Medical Social Services		12.00
12.01	Medical Social Services		12.01
13.00	Home Health Aide		13.00
13.01	Home Health Aide		13.01
14.00	Total (sum of lines 8-13)		14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 150115 | HHA CCN: 157222 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-3 Part II | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
		0	1.00	2.00	3.00	4.00	
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS						
1.00	Physical Therapy	66.00	0.557533	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy						2.00
3.00	Speech Pathology						3.00
4.00	Cost of Medical Supplies	71.00	0.663377	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.227508	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 150115 | HHA CCN: 157222 | Period: From 07/01/2014 To 06/30/2015 | Worksheet H-4 Part I-II | Date/Time Prepared: 11/23/2015 9:52 am

Title XVIII | Home Health Agency I | PPS

		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount 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(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	1,361	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	-1,361	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	1,189,102	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	36,382	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	21,327	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	22,233	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	13,132	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	50	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	1,280,865	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	1,280,865	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	1,280,865	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	1,280,865	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	1,280,865	31.00
31.01	Sequestration adjustment (see instructions)	0	25,618	31.01
32.00	Interim payments (see instructions)	0	1,255,247	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 150115 HHA CCN: 157222	Period: From 07/01/2014 To 06/30/2015	Worksheet H-5 Date/Time Prepared: 11/23/2015 9:52 am
		Home Health Agency I	PPS

		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		0		1,255,247	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			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		1,255,247	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		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			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		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		1,255,247	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT | Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet L Parts I-III Date/Time Prepared: 11/23/2015 9:52 am

	Title XVIII	Hospital	PPS	
			1.00	
	PART I - FULLY PROSPECTIVE METHOD			
	CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier		1,467,580	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		3,723	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		42.61	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		1,471,303	12.00

			1.00	
	PART II - PAYMENT UNDER REASONABLE COST			
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00

			1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00

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

Provider CCN: 150115 | Component CCN: 158507 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/23/2015 9:52 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	36,332	0	36,332	0	36,332	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	125,827	0	125,827	0	125,827	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	7,752	0	7,752	1,016	8,768	9.00
10.00	Subtotal (sum of lines 1 through 9)	169,911	0	169,911	1,016	170,927	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	17,340	17,340	0	17,340	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	69,257	92,073	161,330	0	161,330	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	69,257	109,413	178,670	0	178,670	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	239,168	109,413	348,581	1,016	349,597	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	239,168	109,413	348,581	1,016	349,597	32.00

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

Provider CCN: 150115 | Component CCN: 158507 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/23/2015 9:52 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	36,332	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	125,827	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	8,768	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	170,927	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	17,340	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	-3,829	157,501	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	-3,829	174,841	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-3,829	345,768	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-3,829	345,768	32.00

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

Provider CCN: 150115 | Component CCN: 158508 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/23/2015 9:52 am

Rural Health Clinic (RHC) II | Cost

		Compensation	Other Costs	Total (col. 1 + col. 2)	Reclassifications	Reclassified Trial Balance (col. 3 + col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physician	180,185	0	180,185	0	180,185	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	102,121	0	102,121	0	102,121	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	84,568	0	84,568	1,538	86,106	9.00
10.00	Subtotal (sum of lines 1 through 9)	366,874	0	366,874	1,538	368,412	10.00
11.00	Physician Services Under Agreement	0	0	0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	0	0	0	12.00
13.00	Other Costs Under Agreement	0	0	0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	0	0	0	14.00
15.00	Medical Supplies	0	23,858	23,858	0	23,858	15.00
16.00	Transportation (Health Care Staff)	0	0	0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	0	0	0	17.00
18.00	Professional Liability Insurance	0	0	0	0	0	18.00
19.00	Other Health Care Costs	67,146	34,563	101,709	0	101,709	19.00
20.00	Allowable GME Costs	0	0	0	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	67,146	58,421	125,567	0	125,567	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	434,020	58,421	492,441	1,538	493,979	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24.00
25.00	Optometry	0	0	0	0	0	25.00
26.00	All other nonreimbursable costs	0	0	0	0	0	26.00
27.00	Nonallowable GME costs	0	0	0	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0	0	0	0	29.00
30.00	Administrative Costs	0	0	0	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	0	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	434,020	58,421	492,441	1,538	493,979	32.00

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

Provider CCN: 150115 | Component CCN: 158508 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-1 | Date/Time Prepared: 11/23/2015 9:52 am

Rural Health Clinic (RHC) II | Cost

		Adjustments	Net Expenses for Allocation (col. 5 + col. 6)	
		6.00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physician	0	180,185	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	102,121	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	86,106	9.00
10.00	Subtotal (sum of lines 1 through 9)	0	368,412	10.00
11.00	Physician Services Under Agreement	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0	12.00
13.00	Other Costs Under Agreement	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0	14.00
15.00	Medical Supplies	0	23,858	15.00
16.00	Transportation (Health Care Staff)	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0	17.00
18.00	Professional Liability Insurance	0	0	18.00
19.00	Other Health Care Costs	-19,850	81,859	19.00
20.00	Allowable GME Costs	0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	-19,850	105,717	21.00
22.00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-19,850	474,129	22.00
	COSTS OTHER THAN RHC/FQHC SERVICS			
23.00	Pharmacy	0	0	23.00
24.00	Dental	0	0	24.00
25.00	Optometry	0	0	25.00
26.00	All other nonreimbursable costs	0	0	26.00
27.00	Nonallowable GME costs	0	0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	28.00
	FACILITY OVERHEAD			
29.00	Facility Costs	0	0	29.00
30.00	Administrative Costs	0	0	30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	0	0	31.00
32.00	Total facility costs (sum of lines 22, 28 and 31)	-19,850	474,129	32.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-2

Component CCN: 158507 | Date/Time Prepared: 11/23/2015 9:52 am

Rural Health Clinic (RHC) I | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.12	357	4,200	504		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.96	3,171	2,100	2,016		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.08	3,528		2,520	3,528	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.08	3,528			3,528	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)	345,768	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)	345,768	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)	0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	265,676	15.00
16.00	Total overhead (sum of lines 14 and 15)	265,676	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	265,676	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	265,676	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	611,444	20.00

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

Provider CCN: 150115 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-2

Component CCN: 158508 | Date/Time Prepared: 11/23/2015 9:52 am

Rural Health Clinic (RHC) II | Cost

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions						
1.00	Physician	0.88	3,863	4,200	3,696		1.00
2.00	Physician Assistant	0.00	0	2,100	0		2.00
3.00	Nurse Practitioner	0.90	2,734	2,100	1,890		3.00
4.00	Subtotal (sum of lines 1 through 3)	1.78	6,597		5,586	6,597	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	1.78	6,597			6,597	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)	474,129	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)	474,129	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)	0	14.00
15.00	Parent provider overhead allocated to facility (see instructions)	498,360	15.00
16.00	Total overhead (sum of lines 14 and 15)	498,360	16.00
17.00	Allowable GME overhead (see instructions)	0	17.00
18.00	Subtotal (see instructions)	498,360	18.00
19.00	Overhead applicable to RHC/FQHC services (line 13 x line 18)	498,360	19.00
20.00	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)	972,489	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2014 To 06/30/2015	Worksheet M-3 Date/Time Prepared: 11/23/2015 9:52 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)		611,444	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		3,165	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		608,279	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		3,528	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)		3,528	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		172.41	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	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	79.80	79.80	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	1,350	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	107,730	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		107,730	16.00
16.01	Total program charges (see instructions)(from contractor's records)		257,489	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		243	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		102	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.)		67,562	16.04
16.05	Total program cost (see instructions)		67,664	16.05
17.00	Primary payer amounts		283	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		23,175	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		46,814	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		67,381	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		3,024	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		70,405	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		70,405	26.00
26.01	Sequestration adjustment (see instructions)		1,408	26.01
27.00	Interim payments		64,537	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)		4,460	29.00
30.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, chapter I, §115.2		0	30.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 150115 Component CCN: 158508	Period: From 07/01/2014 To 06/30/2015	Worksheet M-3 Date/Time Prepared: 11/23/2015 9:52 am
	Title XVIII	Rural Health Clinic (RHC) II	Cost

			1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			
1.00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line 20)		972,489	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, line 15)		8,841	2.00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)		963,648	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)		6,597	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)		6,597	6.00
7.00	Adjusted cost per visit (line 3 divided by line 6)		146.07	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	79.80	8.00
9.00	Rate for Program covered visits (see instructions)	79.80	79.80	9.00
	CALCULATION OF SETTLEMENT			
10.00	Program covered visits excluding mental health services (from contractor records)	0	2,094	10.00
11.00	Program cost excluding costs for mental health services (line 9 x line 10)	0	167,101	11.00
12.00	Program covered visits for mental health services (from contractor records)	0	0	12.00
13.00	Program covered cost from mental health services (line 9 x line 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions)	0	0	14.00
15.00	Graduate Medical Education Pass Through Cost (see instructions)		0	15.00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		167,101	16.00
16.01	Total program charges (see instructions)(from contractor's records)		307,194	16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		76	16.02
16.03	Total program preventive costs ((line 16.02/line 16.01) times line 16)		41	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.)		106,795	16.04
16.05	Total program cost (see instructions)		106,836	16.05
17.00	Primary payer amounts		357	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor records)		33,566	18.00
19.00	Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		54,711	19.00
20.00	Net Medicare cost excluding vaccines (see instructions)		106,479	20.00
21.00	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		8,707	21.00
22.00	Total reimbursable Program cost (line 20 plus line 21)		115,186	22.00
23.00	Allowable bad debts (see instructions)		0	23.00
23.01	Adjusted reimbursable bad debts (see instructions)		0	23.01
24.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	24.00
25.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	25.00
25.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	25.50
26.00	Net reimbursable amount (see instructions)		115,186	26.00
26.01	Sequestration adjustment (see instructions)		2,304	26.01
27.00	Interim payments		102,532	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)		10,350	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: 150115 Component CCN: 158507	Period: From 07/01/2014 To 06/30/2015	Worksheet M-4 Date/Time Prepared: 11/23/2015 9:52 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)	170,927	170,927	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	388	1,402	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	388	1,402	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	345,768	345,768	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	265,676	265,676	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001122	0.004055	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	298	1,077	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	686	2,479	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	6	88	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	114.33	28.17	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	6	83	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	686	2,338	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)		3,165	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)		3,024	16.00

COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

Provider CCN: 150115 | Component CCN: 158508 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-4 | Date/Time Prepared: 11/23/2015 9:52 am

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

		Pneumococcal	Influenza	
		1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	368,412	368,412	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,618	2,692	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,618	2,692	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	474,129	474,129	6.00
7.00	Total overhead (from Wkst. M-2, line 16)	498,360	498,360	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.003413	0.005678	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	1,701	2,830	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9)	3,319	5,522	10.00
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	25	169	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/line 11)	132.76	32.67	12.00
13.00	Number of pneumococcal and influenza vaccine injections administered to Program beneficiaries	24	169	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13)	3,186	5,521	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)		8,841	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)		8,707	16.00

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES	Provider CCN: 150115 Component CCN: 158507	Period: From 07/01/2014 To 06/30/2015	Worksheet M-5 Date/Time Prepared: 11/23/2015 9:52 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		64,537	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		64,537	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		4,460	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		68,997	7.00

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

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

Provider CCN: 150115 | Component CCN: 158508 | Period: From 07/01/2014 To 06/30/2015 | Worksheet M-5 | Date/Time Prepared: 11/23/2015 9:52 am

Rural Health Clinic (RHC) II | Cost

		Part B		
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00	Total interim payments paid to provider		102,532	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)			3.00
	Program to Provider			
3.01			0	3.01
3.02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
	Provider to Program			
3.50			0	3.50
3.51			0	3.51
3.52			0	3.52
3.53			0	3.53
3.54			0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)		102,532	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		10,350	6.01
6.02	SETTLEMENT TO PROGRAM		0	6.02
7.00	Total Medicare program liability (see instructions)		112,882	7.00

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