Heal th Financia	al Systems	JASPER COUNTY HOS	SPI TAL	In Lieu	u of Form CMS	5-2552-10
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Failu	re to report can resu	ult in all interim	FORM APPROV	ED
payments made	since the beginning of the cost	reporting period being d	eemed overpayments (4	42 USC 1395g).	OMB NO. 093	3-0050
HOSPITAL AND H AND SETTLEMENT	IOSPITAL HEALTH CARE COMPLEX COS SUMMARY	T REPORT CERTIFICATION	Provider CCN: 151324	From 01/01/2015	Worksheet S Parts I-III Date/Time P 8/15/2016 4	repared:
PART I - COST	REPORT STATUS					
Provi der	1. [ X ] Electronically filed co	ost report		Date: 8/15/20	16 Time:	4:08 pm
use only	2. [ ] Manually submitted cost	report				
	3. [ 1 ] If this is an amended r 4. [ F ] Medicare Utilization. E			resubmitted this co	ost report	
Contractor use only	(1) Ås Submitted 7. (2) Settled without Audit 8.	Date Received: Contractor No. [ N ]Initial Report for [ N ]Final Report for th	this Provider CCN 12.	NPR Date: Contractor's Vendo [ 0 ]If line 5, co number of tim	lumn 1 is 4:	
PART II - CERT	I FI CATI ON					
MI SREPRESENTAT	ION OR FALSIFICATION OF ANY INF	ORMATION CONTAINED IN THE	S COST REPORT MAY BE	PUNISHABLE BY CRIM	INAL CLVLI	

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.

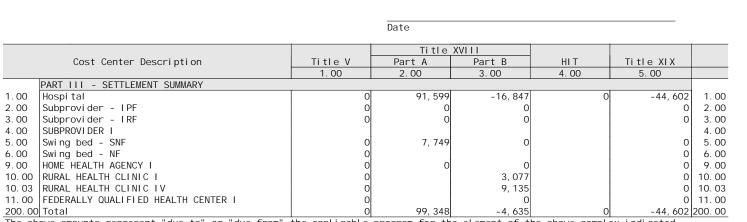
## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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 JASPER COUNTY HOSPITAL (151324) for the cost reporting period beginning 01/01/2015 and ending 08/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)

Title

Officer or Administrator of Provider(s)



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.

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX		<u>COUNTY HC</u> TA	Provi de	er CCN:		Period: From 01/01, To 08/31,	/2015	<u>u of For</u> Workshe Part I Date/Ti 8/15/20	et S-2 me Pre	pare
	1.00		00	3.	00			4.00	5/15/20		
	Hospital and Hospital Health Care Co										
	Street: 1104 EAST GRACE STREET	PO Box:	N 7:	in Codo.	47070	Count					1.
00	City: RENSSELAER	State: I Component Na		ip Code: CCN	47978- CBSA	Provi der	y: JASPER Date	Payme	ent Syst	om (P	<u> </u>
					lumber	Type	Certi fi ed		, 0, or		
								V	XVIII		1
		1.00	2	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
0	Hospital and Hospital-Based Componer Hospital	t Identification: UASPER COUNTY HOS		51324	99915	1	02/03/2005	N	0	0	3.
0	Subprovider - IPF	JASPER COUNTY HUS	SPITAL 1	51324	99915		02/03/2005	I N		0	4.
0	Subprovider - IRF										5.
0	Subprovider - (Other)										6.
0	Swing Beds - SNF	JASPER COUNTY HOS	SPITAL 15	5Z324	99915		12/31/2005	N	0	N	7.
0 0	Swing Beds - NF										8.
	Hospi tal-Based SNF Hospi tal-Based NF										10.
	Hospi tal -Based OLTC										11.
	Hospital-Based HHA	JASPER COUNTY HOS	SPITAL   15	57149	99915		05/13/1985	N	P	N	12.
	Separately Certified ASC						00/15/15				13.
	Hospital-Based Hospice Hospital-Based Health Clinic - RHC	JASPER COUNTY HOS WHEATFIELD CLINIC			99915 99915		03/12/1993		0	N	14.
	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - RHC	BROOK			99915 99915		01/01/2005			N	15.
	IV										
	Hospital-Based Health Clinic - FQHC										16.
	Hospital-Based (CMHC) I										17.
	Renal Dialysis Other										18.   19.
							From		То	:	
							1.00		2.0		
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01/2	015	08/31/	2015	20.
00	Inpatient PPS Information						7				21.
00	Does this facility qualify and is it	currently receiv	ing paymen	ts for d	i spropo	rtionate	N		N		22.
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, en				106(c)(	2) (Pi ckl e	9				
01	Did this hospital receive interim un				cost re	portina	N		N		22.
	period? Enter in column 1, "Y" for y										
	reporting period occurring prior to										
	for no for the portion of the cost r (see instructions)	eporting period o	occurring o	on or aft	er Octo	ber 1.					
02	Is this a newly merged hospital that	requires final u	Incompensat	ed care	pavment	s to be	N		N		22.
	determined at cost report settlement	? (see instructio	ns) Enter	in colum	n 1, "Y	" for yes					
	or "N" for no, for the portion of th										
	in column 2, "Y" for yes or "N" for or after October 1.	no, for the porti	on of the	cost rep	orting	period or	ו				
03	Did this hospital receive a geograph	i c_reclassi fi cati	on from ur	ban to r	ural as	a result	t N		N		22.
	of the OMB standards for delineating	statistical area	s adopted	by CMS i	n FY201	5? Enter	-				
	in column 1, "Y" for yes or "N" for	no for the portio	n of the c	ost repo	rting p	eri od					
	prior to October 1. Enter in column cost reporting period occurring on c						9				
	hospital contain at least 100 but no						ר				
	42 CFR 412.105)? Enter in column 3,										
	Which method is used to determine Me	2						0			23.
00	1, enter 1 if date of admission, 2 i										
00	method of identifying the days in th										
00	method of identifying the days in th used in the prior cost reporting per	<u>iod? In column 2</u>	, enter i				Out-of	<i>l</i> edi ca		ther	
00		iod? In column 2	In-State	In-Stat		ut-of			ys   Mea	i cai d	
00		iod? In column 2	In-State Medicaid	Medi cai	d S	tate	State I	IMO da	d l		
00		iod? In column 2	In-State		d S e Mec	tate dicaid M		IMO da	d	ays	
00		iod? In column 2	In-State Medicaid paid days	Medi cai el i gi bl unpai o days	d S e Mec pai	tate dicaid M d days e	State I Medicaid eligible unpaid				
	used in the prior cost reporting per	-	In-State Medicaid paid days 1.00	Medi cai el i gi bl unpai o days 2.00	d S e Mec b pai	tate dicaid M d days e 3.00	State I Medicaid el i gi bl e unpai d 4.00	1MO da 5. 00	6	. 00	
	used in the prior cost reporting per	, enter the	In-State Medicaid paid days	Medi cai el i gi bl unpai o days 2.00	d S e Mec pai	tate dicaid M d days e	State I Medicaid eligible unpaid				24.
	used in the prior cost reporting per If this provider is an IPPS hospital in-state Medicaid paid days in colum	, enter the n 1, in-state	In-State Medicaid paid days 1.00	Medi cai el i gi bl unpai o days 2.00	d S e Mec b pai	tate dicaid M d days e 3.00	State I Medicaid el i gi bl e unpai d 4.00		6	. 00	24.
	lised in the prior cost reporting per lf this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col	, enter the n 1, in-state umn 2, olumn 3,	In-State Medicaid paid days 1.00	Medi cai el i gi bl unpai o days 2.00	d S e Mec b pai	tate dicaid M d days e 3.00	State I Medicaid el i gi bl e unpai d 4.00		6	. 00	24.
	lf this provider is an IPPS hospital in-state Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid paid days in co out-of-state Medicaid paid days in c	, enter the n 1, in-state umn 2, olumn 3, d days in column	In-State Medicaid paid days 1.00	Medi cai el i gi bl unpai o days 2.00	d S e Mec b pai	tate dicaid M d days e 3.00	State I Medicaid el i gi bl e unpai d 4.00		6	. 00	24.
	If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu	, enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in	In-State Medicaid paid days 1.00	Medi cai el i gi bl unpai o days 2.00	d S e Mec b pai	tate dicaid M d days e 3.00	State I Medicaid el i gi bl e unpai d 4.00		6	. 00	24.
00	If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	, enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6.	In-State Medicaid paid days 1.00 0	Medi cai el i gi bl unpai c days 2.00	d S e Mec b pai	tate Jicaid M d days 6 3.00 0	State I Medicaid el i gi bl e unpai d 4.00		6	. 00	
00	If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu	, enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state	In-State Medicaid paid days 1.00	Medi cai el i gi bl unpai c days 2.00	d S e Mec pai	tate dicaid M d days e 3.00	State I Medicaid eligible unpaid 4.00 0		0	. 00	
00	lf this provider is an IPPS hospital in-state Medicaid paid days in colur Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	, enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state umn 2,	In-State Medicaid paid days 1.00 0	Medi cai el i gi bl unpai c days 2.00	d S e Mec pai	tate Jicaid M d days 6 3.00 0	State I Medicaid eligible unpaid 4.00 0		0	. 00	24.
00	If this provider is an IPPS hospital in-state Medicaid paid days in colur Medicaid eligible unpaid days in col out-of-state Medicaid paid days in co out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the	, enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state umn 2, 3, out-of-state	In-State Medicaid paid days 1.00 0	Medi cai el i gi bl unpai c days 2.00	d S e Mec pai	tate Jicaid M d days 6 3.00 0	State I Medicaid eligible unpaid 4.00 0		0	. 00	

HOSPI TA	Financial Systems JASPER L AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Y HOSPITAL Provider (		eriod: rom 01/01/2015		8-2
						8/15/2016	<u>3:56 pm</u>
					Urban/Rural 3	S Date of Geo 2.00	ogr
26.00 E	Enter your standard geographic classification (not wa	ige) sta	atus at the beg	inning of the		2	26.00
27.00 E	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	nge) sta ""2" fo	atus at the end or rural. If ap			2	27.00
35. 00  I	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0	35.00
					Begi nni ng:	Endi ng:	_
36.00 E	Enter applicable beginning and ending dates of SCH st	atus. S	Subscript line	36 for number	1.00	2.00	36.00
37.00 I	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter s in effect in the cost reporting period.		umber of period	s MDH status		0	37.00
37.01 I	s this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo nstructions)				N		37.01
38.00   g	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.						38.00
					Y/N	Y/N	_
39.00 E	Does this facility qualify for the inpatient hospital	pavmer	nt adjustment f	or low volume	1.00 N	2.00 N	39.00
ł	nospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	)? Ente uiremer or "N"	er in column 1 nts in accordan for no. (see i	"Y" for yes ce with 42 nstructions)			
	s this hospital subject to the HAC program reduction 'N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. E	Enter "Y" for y		N	N	40.00
					V		
45.00 🛛	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	nt for a	li sproporti onat	e share in acc			
46.00  I	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst t. III.					I N N	46.00
47.00   48.00	s this a new hospital under 42 CFR §412.300 PPS capi s the facility electing full federal capital payment Teaching Hospitals				no. N	1 1	
56. 00 🛛	s this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y" f	or yes N	1	56.00
57.00    (       	or "N" for no. f line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for s "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y 'N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or h of th'	"N" for no in his cost report plete Worksheet	column 1. If ing period? E	column 1 Enter "Y"		57.00
58.00 I	fline 56 is yes, did this facility elect cost reimb	oursemer	nt for physicia	ns' services a	is N	1	58.00
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.	N		59.00
60.00 A	Are you claiming nursing school and/or allied health	costs f	°or a program t	hat meets the	N		60.00
R	provider-operated criteria under §413.85? Enter "Y"	Y/N	<u>s or "N" for no</u> IME	<u>Direct GME</u>	IME	Direct GM	E
		1.00	2.00	3.00	4.00	5.00	_
5	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.0	o oc	. 00 61. 00
61.01 E	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		0.00	0.00			61.01
61.02 E	nstructions) Enter the current year total unweighted primary care TE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.00			61.02
61.03 E	ACA). (see instructions) 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		0.00	0.00			61.03
61.04 E	nstructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0. 00	0.00			61.04
61.05 E	current cost reporting period.(see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0.00	0.00			61.05

STITAL AND	HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA	Provider (		riod: om 01/01/2015	Worksheet S-2 Part I	
					To		Date/Time Pre 8/15/2016 3:50	
			Y/N	IME	Direct GME	IME	Direct GME	
0 ( F )			1.00	2.00	3.00	4.00	5.00	
used f	the amount of ACA §5503 aw or cap relief and/or FTEs r general surgery. (see in	that are nonprimary		0.00	0.00			61.
		· · · · · · · · · · · · · · · · · · ·	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
specia for ea column progra unweig FTE un	FTEs in line 61.05, speci lty, if any, and the numbe ch new program. (see instr 1, the program name, ente m code, enter in column 3, hted count and enter in co weighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE Jumn 4, direct GME				0.00		
progra reside instru enter 3, the	FTEs in line 61.05, speci m specialty, if any, and t nts for each expanded prog ctions) Enter in column 1, in column 2, the program c IME FTE unweighted count ect GME FTE unweighted cou	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0.00	0.00	61.
							1.00	
	ovisions Affecting the Hea the number of FTE resident					od for which	0.00	62
your h	ospital received HRSA PCRE the number of FTE resident	funding (see instruc	tions)				0.00	
	in this cost reporting pe ng Hospitals that Claim Re				s)			
.00 Has yo	ur facility trained reside r yes or "N" for no in col	nts in nonprovider se	ettings	during this co		eriod? Enter	N	63.
1110					Unweighted	5	Ratio (col. 1/	
					FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
Caatia	n 5504 of the ACA Base Yea	n FTF Dagidanta in Na		lan Cattinga T	1.00	2.00	3.00	
.00 Enter in the reside settin reside	that begins on or after J in column 1, if line 63 is base year period, the num nt FTEs attributable to ro gs. Enter in column 2 the nt FTEs that trained in yo lumn 1 divided by (column	uly 1, 2009 and befor yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	<u>re June</u> ty train a-primar all non l non-pr n column	30, 2010. The residents by care provider timary care a 3 the ratio	0.00	0.00		64.
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site		Ratio (col. 3/ (col. 3 + col. 4))	
.00 Enter	in column 1, if line 63	1.00		2.00	3.00	4.00	5.00 0.000000	65
is yes traine year p associ FTEs f progra reside	, or your facility d residents in the base eriod, the program name ated with primary care or each primary care m in which you trained nts. Enter in column 2, ogram code, enter in 3, the number of hted primary care FTE nts attributable to				0.00	0.00	0.00000	

Heal th	Financial Systems	JASPEF	R COUNTY HOSPI	TAL		I	n Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA P	rovi der	F	Period: From 01/01, Fo 08/31,		Worksheet S Part I Date/Time P 8/15/2016 3	repared:
					Unweighted FTEs Nonprovider Site	Unwei gh FTEs Hospi t	i n al	Ratio (col. (col. 1 + co 2))	
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider	Setti na	1.00 sEffective f	2.00 For cost re		3.00 na periods	
	<u>beginning on or after July 1, 20</u>	10	•				•		
	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settir ry care reside 3 the ratio of	ngs. ent	0.0		0.00	0.0000	66.00
		Program Name	Program (	Code	Unweighted FTEs Nonprovider Site	Unwei gh FTEs Hospi t	in	Ratio (col. (col. 3 + co 4))	
		1.00	2.00		3.00	4.00	)	5.00	_
	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)				0.0	0	0. 00	0. 0000	00 67.00
			I		1				
	Inpatient Psychiatric Facility P	PS					1.00	0 2.00 3.0	0
70.00	Is this facility an Inpatient Ps	ychiatric Facility (I	PF), or does	it conta	ain an IPF sub	provi der?	N		70.00
71.00	Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions) Inpatient Rehabilitation Facilit	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	004? Enter "\ lity train re (D)? Enter "\	" for ye esidents " for ye	es or "N" for in a new teac es or "N" for	no. (see hing no.		0	71.00
	ls this facility an Inpatient Re subprovider? Enter "Y" for yes	habilitation Facility	/(IRF), or do	es it co	ontain an IRF		N		75.00
76.00	Subprovider? Enter Y for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	mber 15, 2004 new teaching for no. Colum	? Enter program n 3: If	"Y" for yes o in accordance column 2 is Y	r "N" for with 42		0	76.00
								1.00	
81.00	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers					period? E	nter	N N	80. 00 81. 00
85. 00 86. 00	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider (	excl uded uni t				no.	N	85. 00 86. 00
87.00	Is this hospital a "subclause (I			1886(d)	(1)(B)(iv)(II)	? Enter "Y		N	87.00
	for yes or "N" for no.					V		XI X	
	Title V and VIX Services					1.00	)	2.00	
90.00	Title V and XIX Services Does this facility have title V		hospital serv	vi ces? Ei	nter "Y" for	N		Y	90.00
	yes or "N" for no in the applica Is this hospital reimbursed for		nrough the cos	st repor	t either in	N		Y	91.00
	full or in part? Enter "Y" for y Are title XIX NF patients occupy	es or "N" for no in t	the applicable	column.				N	92.00
	instructions) Enter "Y" for yes	or"N" for no in the	applicable co	lumn.					
93.00	Does this facility operate an IC "Y" for yes or "N" for no in the		urposes of tit	ie V and	d XIX? Enter	N		N	93.00
	Does title V or XIX reduce capit applicable column.		or yes, and "N	l" for no	o in the	Ν		N	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	HOSPI TAL		Ir	n Lieu	J OT FORM	CMS-25	52-10
NUSTITAL AND NUSTITAL HEALTH CARE CUMPLEX IDENTIFICATION DATA	Provi der	CCN: 151324	Period: From 01/01/ To 08/31/		Workshee Part I Date/Tim	e Prepa	
			V		8/15/201 XI X		pm
			1.00		2.00		
95.00 If line 94 is "Y", enter the reduction percentage in the appl 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	icable colum or "N" for n	n. o in the	0. 00 N		0. 00 N		95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the appl Rural Providers	icable colum	n.	0.00		0.00	) ç	97.00
105.00 Does this hospital qualify as a critical access hospital (CAH 106.00 If this facility qualifies as a CAH, has it elected the all-i for outpatient services? (see instructions)		hod of paymer	nt N				05.00 06.00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see inst	ructions) lf	st N			10	07. 00
108.00 Is this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.							00 .80
-	Physi cal 1.00	Occupationa 2.00	al Speech 3.00	1	Respira 4.00		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	N	N		N		09. 00
					1.00		10.00
110.00Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" f		on project (4	10A Demo)for	-	N	11	10.00
Miscollappous Cost Poporting Information			-	1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Dub 15 d photor 22	lf column 2 i for long te	is "E", enter rm care (incl	in column udes	N		0 11	15.00
Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" f 117.00 Is this facility legally-required to carry malpractice insura no.			"N" for	N Y			16. 00 17. 00
118.00 Is the malpractice insurance a claims-made or occurrence poli claim-made. Enter 2 if the policy is occurrence.	cy? Enter 1	if the policy	/ is	1		11	18. 00
		Premi ums	Losses	6	Insura	nce	
		1.00	2.00		2.00		
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	0	3.00		
							18.01
			1 00		2.00		18. 01
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein.			1.00 N		2.00	) 11	18. 02
Administrative and General? If yes, submit supporting schedu	le listing co Harmless prov column 1, "Y alifies for th	ost centers vision in ACA " for yes or he Outpatient	N N		2.00	11	
<ul> <li>Administrative and General? If yes, submit supporting schedu and amounts contained therein.</li> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qual Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implar</li> </ul>	le listing co Harmless prov column 1, "Y alifies for ti s? (see inst	ost centers vision in ACA " for yes or he Outpatient ructions)	N N			) 11 11 12	18. 02
Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the	Harmless pro- column 1, "Y alifies for th s? (see inst- ntable devices Enter "Y" for	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N"	N N			) 11 12 12	18. 02 19. 00 20. 00
<ul> <li>Administrative and General? If yes, submit supporting schedu and amounts contained therein.</li> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information</li> </ul>	He listing of Harmless pro- column 1, "Y alifies for ti ss? (see inst ntable devices Enter "Y" for e Worksheet A	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number	N N Y N			) 11 12 12 12	18. 02 19. 00 20. 00 21. 00 22. 00
<ul> <li>Administrative and General? If yes, submit supporting schedu and amounts contained therein.</li> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.</li> </ul>	Harmless pro- column 1, "Y alifies for th s? (see inst- ntable devices Enter "Y" for Worksheet A	vision in ACF " for yes or he Outpatient ructions) s charged to yes or "N" line number	N N N			) 11 12 12 12 12 12	18. 02 19. 00 20. 00 21. 00
<ul> <li>Administrative and General? If yes, submit supporting schedu and amounts contained therein.</li> <li>119.00 DO NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> </ul>	Harmless pro- column 1, "Y alifies for th s? (see inst- ntable devices inter "Y" for worksheet A yes and "N" cer the certifier the certifier	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date	N N N			) 11 12 12 12 12 12 12	18. 02 19. 00 20. 00 21. 00 22. 00 25. 00
Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter	Harmless pro- column 1, "Y alifies for th s? (see inst- ntable devices inter "Y" for worksheet A yes and "N" cer the certifier the certifier	vision in AC/ " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date	N N N			) 11 12 12 12 12 12 12 12 12	18. 02 19. 00 20. 00 21. 00 22. 00 25. 00 26. 00
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<ul> <li>Administrative and General? If yes, submit supporting schedu and amounts contained therein.</li> <li>119.00 D0 NOT USE THIS LINE</li> <li>120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with &lt; 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>129.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.</li> <li>130.00 If this is a Medicare certified pancreas transplant center, enter</li> </ul>	Harmless pro- column 1, "Y alifies for the second of the second table devices and table devices and table devices and the second yes and "N" are the certifies the certifies the certifies	ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date cation date i	N N N Y N N			11 11 12 12 12 12 12 12 12 12 12 12	18. 02 19. 00 20. 00 21. 00 22. 00 25. 00 26. 00 27. 00 28. 00
Administrative and General? If yes, submit supporting schedu and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? E for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified liver transplant center, enter column 1 and termination date, if applicable, in column 2.	Harmless pro- column 1, "Y alifies for th s? (see inst- ntable devices inter "Y" for worksheet A worksheet A yes and "N" er the certifier the certifier the certifier the certifier the certifier anter the certifier anter the certifier anter the certifier anter the certifier anter the certifier	vision in ACP " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date ication date i tification	N N N Y N N			) 11 12 12 12 12 12 12 12 12 12	18. 02 19. 00 20. 00 21. 00 22. 00 25. 00 25. 00 26. 00 27. 00 28. 00 29. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	JASPER COUNTY X IDENTIFICATION DATA			Peri od:	eu of Form CMS- Worksheet S-2	
				From 01/01/201 To 08/31/201		epared: 56 pm
133.00 If this is a Medicare certified ot	her transplant center ent	ter the certifi	cation date	1.00	2.00	133.00
in column 1 and termination date,	if applicable, in column 2	2.				133.00
134.00 If this is an organ procurement or		ne OPO number i	n column 1			134.00
and termination date, if applicabl All Providers						-
140.00 Are there any related organization				N		140.00
chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the						
1.00	2.0			3.00		
If this facility is part of a chai				ame and address	s of the	
home office and enter the home off 141.00Name:	Contractor s Name:	ontractor numbe		or's Number:		141.00
142.00 Street:	PO Box:					142.00
143.00 Ci ty:	State:		Zip Code:	:		143.00
					1.00	-
144.00 Are provider based physicians' cos	ts included in Worksheet A	١?			Y	144.00
				1.00	2.00	-
145.00 If costs for renal services are cl	aimed on Wkst. A, line 74,	are the costs	s for	N	2.00	145.00
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"	for yes or "N" for no in lude Medicare utilization	column 1. If c	column 1 is			
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/c	y changed from the previou column 1. (See CMS Pub. 1			N		146.00
					1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y" for y	/es or "N" for	no.		1.00 N	147.00
148.00 Was there a change in the order of					N	148.00
149.00 Was there a change to the simplifi	ed cost finding method? Er				N N	149.00
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00	-
Does this facility contain a provi		exemption from	n the applica	tion of the low	wer of costs	
or charges? Enter "Y" for yes or " 155.00Hospi tal	<u>N" for no for each compone</u>	ent for Part A N	and Part B. N	<u>(See 42 CFR §4</u> N	13.13) N	155.00
156. 00 Subprovi der – IPF		N	N	N	N	156.00
157.00 Subprovi der – IRF		N	N	N	N	157.00
158. 00 SUBPROVI DER		N	N	N	N	158.00 159.00
159.00 SNF 160.00 HOME_HEALTH_AGENCY		N	N N	N N	N	160.00
161.00 CMHC			N	N	N	161.00
					1.00	-
Multicampus					1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has one	e or more campu	uses in diffe	rent CBSAs?	N	165.00
	Name 0	County		p Code CBSA	FTE/Campus 5.00	-
166.00 If line 165 is yes, for each	0	1.00	2.00	3.00 4.00		0166.00
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
					1.00	-
Health Information Technology (HI 167.00 Is this provider a meaningful user				t Act	Y	1/7 00
168.00 If this provider is a CAH (line 10				, enter the		167.00 0168.00
reasonable cost incurred for the H	IIT assets (see instructior	ıs)				
168.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)?				a hardship		168.01
169.00 If this provider is a meaningful u transition factor. (see instruction	iser (line 167 is "Y") and			"N"), enter the	e 0.0	0169. 00

Health Financial Systems	JASPER COUNTY HOS	SPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	FICATION DATA	Provider CCN: 151324	Period: From 01/01/2015	Worksheet S-2 Part I	
			To 08/31/2015		epared: 6 pm
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	date and ending date	for the reporting	10/01/2014	08/31/2015	170.00
				1.00	
171.00 If line 167 is "Y", does this provider have Medicare cost plans reported on Wkst. S-3, (see instructions)				N	171.00

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 151324	Period: From 01/01/2015 To 08/31/2015	Worksheet S- Part II Date/Time Pr 8/15/2016 3:	epared:
				Y/N	Date	
				1.00	2.00	-
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esponses. Ente	er all dates in t	he	
	mm/dd/yyyy format.					_
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c	olumn 2. (see	instructions]			
			Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	N			3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert	ified Dubli-	Y	A		4.0
. 00 . 00	Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	or Compiled, ilable in	N	A		5.0
	those on the filed financial statements? If yes, submit rec					
			÷	Y/N	Legal Oper.	
				1.00	2.00	-
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	s N		6.0
. 00	Are costs claimed for Allied Health Programs? If "Y" see in	structions.		Ν		7.0
. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	0	Ν		8.0
. 00	Are costs claimed for Interns and Residents in an approved		cal education	Ν		9.0
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.		the current	Ν		10. 0
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.0
				-	<u>Y/N</u> 1.00	
	Bad Debts				1.00	-
2.00	Is the provider seeking reimbursement for bad debts? If yes	, see instruc	tions.		Y	12.0
3. 00	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.	olicy change o	during this co	ost reporting	Ν	13.0
4.00	If line 12 is yes, were patient deductibles and/or co-payme	nts waived? In	fyes, see ins	structions.	N	14. C
5 00	Bed Complement Did total beds available change from the prior cost reporti	ng poriod2 lf	VOS SOO INS	tructions	N	15.0
5.00	The total beas available change from the piron cost report	<u>v</u> 1	rt A	Par		15.0
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only?	N		N		16.0
2.00	lf 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)					
7.00	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	Y	01/13/2016	Y	01/13/2016	17.0
3. 00	in columns 2 and 4. (see instructions) 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	Ν		Ν		18.0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		N		19. 0

	inancial Systems JASPER COUN L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 151324	Peri od:	u of Form CM Worksheet S	
JSFTTAL	L AND HOSFITAL HEALTH CARE RELIMBORSEMENT QUESTIONNALRE	FIOVICEI	CCN. 151524	From 01/01/2015 To 08/31/2015	Part II	repared
		Descri	pti on	Y/N	Y/N	
		(	)	1.00	3.00	
	f line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	× (b)		N	N	20.
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
.00 W	Vas the cost report prepared only using the provider's	1.00	2.00		4.00	21.
	records? If yes, see instructions.					21.
	OMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC				1.00	_
	apital Related Cost	LFT CHILDRENS H	USFTTALS)			
. 00 H	lave assets been relifed for Medicare purposes? If yes, se lave changes occurred in the Medicare depreciation expense		als made dur	ing the cost	N N	22. 23.
r	reporting period? If yes, see instructions.			0		
1	Were new leases and/or amendments to existing leases enter f yes, see instructions	0		01	N	24.
i	lave there been new capitalized leases entered into during nstructions.		0.	5	Y	25.
	Vere assets subject to Sec. 2314 of DEFRA acquired during t nstructions.	he cost reporti	ng period? I	f yes, see	Ν	26.
с	las the provider's capitalization policy changed during th copy.	e cost reportin	g period? If	yes, submit	N	27
. OO W	nterest Expense Were new Loans, mortgage agreements or letters of credit e	ntered into dur	ing the cost	reporting	N	28
00 D	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		bt Service R	eserve Fund)	Y	29
00 H	reated as a funded depreciation account? If yes, see inst las existing debt been replaced prior to its scheduled mat		debt? If yes	, see	Ν	30
. 00 H	nstructions. Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes	, see	Ν	31
	nstructions. urchased Services					
00 H	lave changes or new agreements occurred in patient care se		d through co	ntractual	Y	32
00	arrangements with suppliers of services? If yes, see instr fline 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		g to competi	tive bidding? If	Ν	33
	rovi der-Based Physi ci ans					
	Are services furnished at the provider facility under an a	rrangement with	provi der-ba	sed physi ci ans?	N	34
	f yes, see instructions. f line 34 is yes, were there new agreements or amended ex	isting agreemen	ts with the	provi der-based	Ν	35
p	physicians during the cost reporting period? If yes, see i	nstructions.			<b>D</b> 1	_
				Y/N 1.00	Date 2.00	
H	ome Office Costs			1.00	2.00	
00 W	Vere home office costs claimed on the cost report? fline 36 is yes, has a home office cost statement been p	repared by the	home office?	N		36
1	f yes, see instructions. f line 36 is yes, was the fiscal year end of the home of					38
t	the provider? If yes, enter in column 2 the fiscal year en f line 36 is yes, did the provider render services to oth	d of the home o	ffi ce.			39
s	see instructions. fline 36 is yes, did the provider render services to the		5	N		40
	nstructions.		5			
		1.	00	2.	00	
00 E	ost Report Preparer Contact Information Enter the first name, last name and the title/position meld by the cost report preparer in columns 1, 2, and 3,	KYLE		SMI TH		41
r	respectively. inter the employer/company name of the cost report	BLUE & CO				42
	preparer.					172
	Enter the telephone number and email address of the cost	317-713-7957		KCSMI TH@BLUEAN		43

Heal th	Financial Systems JASF	PER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONN.	AI RE	Provi der	CCN: 151324	Peri od:	Worksheet S-2	
			_		From 01/01/2015 To 08/31/2015		pared: 6 pm
			3.	00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/posit	ti on	MANAGER				41.00
	held by the cost report preparer in columns 1, 2, a	and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the	e cost					43.00
	report preparer in columns 1 and 2, respectively.						

	Financial Systems	JASPER COUNTY	HOS			-		u of Form CMS-2	
HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA		Provi der	CCN: 151324		eriod: com 01/01/2015 o 08/31/2015	Worksheet S-3 Part I Date/Time Pre 8/15/2016 3:50	pared:
								I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Available		CAH Hours	Title V	
		1.00		2.00	3.00	_	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00		21	5, 1	03	48, 600. 00	0	1.00
2.00 3.00 4.00 5.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF							0	2.00 3.00 4.00 5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)			21	5, 1	03	48, 600. 00	0 0	6. 00 7. 00
8.00 9.00 10.00 11.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	31.00		4	9	972	7, 488. 00	0	8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits	43. 00		25	6, C	)75	56, 088. 00	0 0 0	12.00 13.00 14.00 15.00 16.00
16.00 17.00 18.00 19.00 20.00	SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY	41. 00 42. 00		0 0		0 0		0 0	17.00 17.00 18.00 19.00 20.00
21.00 22.00 23.00 24.00 24.10 25.00	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	101. 00 116. 00 30. 00		0		0		0	21.00 22.00 23.00 24.00 24.10 25.00
25.00 26.00 26.03 26.25 27.00 28.00 29.00 30.00	RURAL HEALTH CLINIC RURAL HEALTH CLINIC IV FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction)	88. 00 88. 03 89. 00		25				0 0 0	25.00 26.00 26.25 27.00 28.00 29.00 30.00
30.00 31.00 32.00 32.01	Employee discount days (see fistuction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days			0		0			31.00 32.00 32.01 33.00

OSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 151324		eriod: com 01/01/2015 o 08/31/2015	Worksheet S-3 Part I Date/Time Pre 8/15/2016 3:5	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1, 435	150	2, 02	25			1.0
. 00	HMO and other (see instructions)	176	49					2.0
. 00	HMO IPF Subprovider	0	0					3.0
. 00	HMO IRF Subprovider	0	0					4.0
. 00	Hospital Adults & Peds. Swing Bed SNF	479	0	47	79			5.0
. 00	Hospital Adults & Peds. Swing Bed NF		0	c	90			6.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 914	150	2, 59	94			7.0
. 00	INTENSIVE CARE UNIT	160	0	18	86			8.0
. 00	CORONARY CARE UNI T							9.0
0. 00	BURN INTENSIVE CARE UNIT							10.0
1.00	SURGICAL INTENSIVE CARE UNIT							11.0
2.00	OTHER SPECIAL CARE (SPECIFY)							12.0
3.00	NURSERY		0		0			13.0
4.00	Total (see instructions)	2,074	150	2, 78	80	0.00	186.04	14.0
5.00	CAH visits	0	0		0			15.0
6.00	SUBPROVIDER - IPF							16.0
7.00	SUBPROVIDER - IRF	0	0		0	0.00	0.00	17.0
8.00	SUBPROVIDER		0		0	0,00	0.00	
9.00	SKILLED NURSING FACILITY							19.0
0.00	NURSING FACILITY							20.0
1.00	OTHER LONG TERM CARE							21.0
2.00	HOME HEALTH AGENCY	5, 978	2, 513	11, 58	89	0.00	17.21	
3.00	AMBULATORY SURGICAL CENTER (D. P. )	0, , , 0	2,010	,		01.00		23.0
4.00	HOSPI CE	2, 324	39	2, 87	76	0.00	2.04	
4.10	HOSPICE (non-distinct part)	2,021	0	2, 0.	0	0100	2.01	24.1
5.00	CMHC - CMHC	U U	U U		Ŭ			25.0
6.00	RURAL HEALTH CLINIC	128	122	1, 92	23	0.00	2.47	
6. 03	RURAL HEALTH CLINIC IV	519	810	2, 98		0.00	2.50	
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	2, 70	0	0.00	0.00	
7.00	Total (sum of lines 14-26)	0	0		0	0.00	210.26	
3.00	Observation Bed Days		0	1, 00	04	0.00	210.20	28.0
9.00	Ambul ance Trips	0	0	1, 00				29.0
D. 00	Employee discount days (see instruction)	0			20			30.0
1.00	Employee discount days - IRF				20			31.0
2.00	Labor & delivery days (see instructions)	0	0		0			32.0
		0	0		0			
2. 01	Total ancillary labor & delivery room				U			32.0
	outpatient days (see instructions) LTCH non-covered days							33. (

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 151324	Period: From 01/01/2015 To 08/31/2015	Worksheet S-3 Part I Date/Time Pre 8/15/2016 3:5	pared:
		Full Time Equivalents		Di s	charges	0/13/2010 3. 3	
	Component	Nonpai d 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) HMO and other (see instructions)		0	3	92 43 36 25	565	2.00
2.00 3.00 4.00 5.00 6.00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF				0		3.00 4.00 5.00
7.00 8.00 9.00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT						7.00 8.00 9.00
10.00 11.00 12.00 13.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						10.00 11.00 12.00
14.00 15.00 16.00	Total (see instructions) CAH visits SUBPROVIDER - IPF	0. 00	0	3	92 43	565	
17.00 18.00 19.00 20.00 21.00	SUBPROVI DER - I RF SUBPROVI DER SKI LLED NURSI NG FACI LI TY NURSI NG FACI LI TY OTHER LONG TERM CARE	0. 00 0. 00	0		0 0 0	0 0	17.00 18.00 19.00 20.00 21.00
22.00 23.00 24.00 24.10	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part)	0. 00 0. 00					22.00 23.00 24.00 24.10
25.00 26.00 26.03	CMHC - CMHC RURAL HEALTH CLINIC RURAL HEALTH CLINIC IV	0.00					25.00 26.00 26.03
26.25 27.00 28.00 29.00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips	0. 00 0. 00					26. 25 27. 00 28. 00 29. 00
30. 00 31. 00 32. 00 32. 01	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpationt days (see instructions)						30.00 31.00 32.00 32.01
33.00	outpatient days (see instructions) LTCH non-covered days						33.0

Heal th	Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
HOME I	IEALTH AGENCY STATI STI CAL DATA			CCN: 151324	Period: From 01/01/2015		
			Component	t CCN: 157149	To 08/31/2015	8/15/2016 3:5	
					Home Health Agency I	PPS	
					1.	00	-
0.00	County	<b>T</b> : 11 M	<b>T</b> : 11 - 20/1-1-1		JASPER		0.00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	C		0 0	0	1.00
2.00	Unduplicated Census Count (see instructions)	0.00		0.0	0.00	0.00	
				Number of Em	ployees (Full Ti	me Equivalent)	
		Enter the numb	er of hours in	Staff	Contract	Total	
		your normal	work week				
		(	)	1.00	2.00	3.00	
3.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		0.00	0.0	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		0.00	0.0	0.00	0.00	4.00
5.00 6.00	Other Administrative Personnel Direct Nursing Service			0.0			
7.00	Nursing Supervisor			0.0	0. 00	0.00	7.00
8.00 9.00	Physical Therapy Service Physical Therapy Supervisor			0.0			
10.00	Occupational Therapy Service			0.0	0.00	0.00	10.00
11.00 12.00	Occupational Therapy Supervisor Speech Pathology Service			0.0			1
13.00	Speech Pathology Supervisor			0.0	0.00	0.00	13.00
14.00 15.00	Medical Social Service Medical Social Service Supervisor			0.0			
16.00	Home Health Aide			0.0	0. 00	0.00	
17.00 18.00	Home Health Aide Supervisor Other (specify)			0.0			
19. 00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where				2		19.00
19.00	you provided services during the cost				2		19.00
20.00	reporting period. List those CBSA code(s) in column 1 serviced			23844			20.00
20100	during this cost reporting period (line 20			20011			20100
20. 01	contains the first code).			50031			20. 01
		Full Ep Without	oisodes With Outliers	LUPA Enicodo	s PEP Only	Total (cols.	
		Outliers			Epi sodes	1-4)	
	PPS ACTIVITY DATA	1.00	2.00	3.00	4.00	5.00	
21. 00 22. 00	Skilled Nursing Visits Skilled Nursing Visit Charges	1, 581 210, 273			51 31 13 4, 123		
22.00	Physical Therapy Visits	1, 219			13 4, 123		
24.00 25.00	Physical Therapy Visit Charges Occupational Therapy Visits	175, 536 317			72 3, 744	190, 512 339	
26.00	Occupational Therapy Visit Charges	45, 648	2, 016		1, 008		26.00
27.00 28.00	Speech Pathology Visits Speech Pathology Visit Charges	130 20, 150			1 1 55 155	145 22, 475	
29.00	Medical Social Service Visits	18	5		0 0	23	29.00
30.00 31.00	Medical Social Service Visit Charges Home Health Aide Visits	3, 726			0 0 3 22	4, 761 1, 944	
32.00	Home Health Aide Visit Charges	63, 000	57, 897	18	39 1, 386	122, 472	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	4, 265	1, 547		79 87	5, 978	33.00
34.00	Other Charges	E19 222	-		0 0	0	
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	518, 333	142, 946	10, 4	73 10, 416	682, 168	35.00
36.00	Total Number of Episodes (standard/non outlier)	204		:	28 2	234	36.00
37.00	Total Number of Outlier Episodes		18		2		37.00
38.00	Total Non-Routine Medical Supply Charges	13, 846	11, 342	32	26 0	25, 514	38.00

Heal th	Financial Systems	JASPER COUNTY I	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	AL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFI	ED HEALTH CENTER	R Provi der		Period: From 01/01/2015	Worksheet S-8	
STATIS	TICAL DATA		Component		To 08/31/2015	Date/Time Pre 8/15/2016 3:5	pared: 6 pm
					Rural Health Clinic (RHC) I	Cost	
					1.	00	
1.00	Clinic Address and Identification Street				492 S BIERMA S	T !	1.00
			Ci	ty	State	ZIP Code	
2.00	City Ctata 71D Cada County		1.	00	2.00	3.00	2.00
2.00	City, State, ZIP Code, County	WHI	EATFIELD		IN	47978	2.00
						1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural	or "U" for urba	n		Grant Award	0 Date	3.00
					1.00	2.00	
	Source of Federal Funds						
4.00 5.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac				0		4.00 5.00
6.00	Heal th Services for the Homeless (Section 340				0		6.00
7.00	Appalachian Regional Commission				0		7.00
8.00 9.00	Look-Alikes OTHER (SPECIFY)				0		8.00 9.00
9.00					0		9.00
9.02					0		9. 02
9.03 9.04					0		9.03 9.04
9.04 9.05					0		9.04
9.06					0		9.06
9.07					0		9.07
9.08 9.09					0		9.08 9.09
9.10					0		9.10
					1.00	2.00	
10.00	Does this facility operate as other than an R	HC or FQHC? Ente	r "Y" for ye	s or "N" for	N	0	10.00
	no in column 1. If yes, indicate number of ot						
	subscripts of line 11 the type of other opera	sundavia			Inday	Tuesday	
		from	to	from	to	from	
	Facility hours of energians (1)	1.00	2.00	3.00	4.00	5.00	
11.00	Facility hours of operations (1) Clinic			08: 00	17:00	08:00	11.00
12.00	Have you received an approval for an exception	n to the product	ivity standa	rd?	1.00 N	2.00	12.00
13.00	Is this a consolidated cost report as defined				N	0	•
	30.8? Enter "Y" for yes or "N" for no in colu						
	number of providers included in this report. numbers below.	List the names o	f all provid	ers and			
					der name	CCN number	
11.00				1	. 00	2.00	11.00
14.00	Provider name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
		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						15.00
	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)					l	

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10		
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	IED HEALTH CEN	TER Provi der	CCN: 151324	Period: From 01/01/2015	Worksheet S-8	3		
STATI STI CAL DATA	Componen	t CCN: 153990						
				Rural Health	Cost			
				<u>Clinic (RHC) I</u>				
		Cou	inty					
		4.	00					
2.00 City, State, ZIP Code, County		JASPER				2.00		
	Tuesday	Wedn	esday	Thur	sday			
	to	from	to	from	to			
	6.00	7.00	8.00	9.00	10.00			
Facility hours of operations (1)								
11.00 Clinic	17:00	08: 00	17:00	08:00	17:00	11.00		
	Fri	day	Sa	turday				
	from	to	from	to				
	11.00	12.00	13.00	14.00				
Facility hours of operations (1)								
11. 00 Cl i ni c	08: 00	17:00				11.00		

Heal th	Financial Systems	JASPER COUNTY HO	SPI TAL		In Lie	eu of Form CMS-:	2552-10
	AL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF			CCN: 151324	Peri od:	Worksheet S-8	
STATI S	TI CAL DATA		Component	CCN: 158502	From 01/01/2015 To 08/31/2015		pared: 6 pm
					Rural Health Clinic (RHC) IV	Cost	
	1				1.	00	
1.00	Clinic Address and Identification Street				420 E MAIN ST	1	1.00
1.00	511 661		Ci	tv	State	ZIP Code	1.00
			1.		2.00	3.00	
2.00	City, State, ZIP Code, County	BROO	ЭК		IN	47922	2.00
						1.00	
3.00	FQHCs ONLY: Designation - Enter "R" for rural	or "U" for urban				0	3.00
	<u></u>				Grant Award	Date	
					1.00	2.00	
4 00	Source of Federal Funds	A = + )				1	1 4 00
4.00 5.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac				0		4.00 5.00
6.00	Heal th Services for the Homeless (Section 340				0		6.00
7.00	Appalachian Regional Commission				0		7.00
8.00	Look-Alikes				0		8.00
9.00	OTHER (SPECI FY)				0		9.00
9. 01 9. 02					0		9. 01 9. 02
9.02 9.03					0		9.02
9.04					0		9.04
9.05					0		9.05
9.06					0		9.06
9.07					0		9.07
9.08 9.09					0		9.08 9.09
9.09 9.10					0		9.10
	<u> </u>			_			
10.00					1.00	2.00	10.00
10. 00	Does this facility operate as other than an F no in column 1. If yes, indicate number of ot subscripts of line 11 the type of other opera	her operations in	column 2. (	Enter in	N	0	10.00
	subscripts of the trans type of other operation	Sunday	scrating no		onday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) Clinic			08: 00	17:00	08: 00	11.00
11.00				00.00	17.00	00.00	11.00
					1.00	2.00	
	Have you received an approval for an exception				N	_	12.00
13.00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu				N	0	13.00
	number of providers included in this report. numbers below.						
				Provi	der name	CCN number	
	1				1. 00	2.00	
14.00	Provider name, CCN number	)/ /hl			NI N	<b>T</b> 1 1 100 11	14.00
		Y/N 1.00	V 2.00	XVIII 3.00	4. 00	Total Visits 5.00	
15.00	Have you provided all or substantially all	1.00	2.00	5.00	4.00	5.00	15.00
	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)					l	

Health Financial Systems	JASPER COUNT	TY HOSPI TAL		In Lie	eu of Form CMS-	2552-10			
	HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CEN				Worksheet S-8				
STATI STICAL DATA	Componen	t CCN: 158502	From 01/01/2015 To 08/31/2015		pared: 6 pm				
				Rural Health	Cost				
			Clinic (RHC) IV						
		Cou	inty						
		4.	00						
2.00 City, State, ZIP Code, County		JASPER				2.00			
	Tuesday	Wedn	esday	Thur	sday				
	to	from	to	from	to				
	6.00	7.00	8.00	9.00	10.00				
Facility hours of operations (1)									
11.00 Clinic	17:00	08: 00	17:00	08:00	17:00	11.00			
	Fri	day	Sa	turday					
	from	to	from	to	1				
	11.00	12.00	13.00	14.00	1				
Facility hours of operations (1)	Facility hours of operations (1)								
11.00 Clinic	08: 00	17:00				11.00			

Heal th	Financial Systems		JASPER COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
HOSPI T	AL IDENTIFICATION DATA				CCN: 151324 CCN: 151519	Period: From 01/01/2015 To 08/31/2015	Worksheet S-9 Parts I & II Date/Time Prep 8/15/2016 3:56		
						Hospi ce I			
		Unduplicated Days							
		Title XVIII	Title XIX	Title XVIII Skilled	Title XIX Nursing	All Other	Total (sum of cols. 1, 2 &		
				Nursing Facility	Facility		5)		
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART I - ENROLLMENT DAYS								
1.00	Continuous Home Care	0	0	0		0 0	0	1.00	
2.00	Routine Home Care	2, 308	39	0		0 513	2, 860	2.00	
3.00	Inpatient Respite Care	10	0	0		0 0	10	3.00	
4.00	General Inpatient Care	6	0	0		0 0	6	4.00	
5.00	Total Hospice Days	2, 324	39	0		0 513	2, 876	5.00	
	Part II - CENSUS DATA								
6.00	Number of Patients Receiving	50	3	0		0 13	66	6.00	
	Hospi ce Care								
7.00	Total Number of Unduplicated	0.00		0.00				7.00	
	Continuous Care Hours Billable								
	to Medicare								
8.00	Average Length of Stay (line	46.48	13.00	0.00	0.	39.46	43. 58	8.00	
	5/line 6)	10							
9.00	Unduplicated Census Count	48	3	0		0 15	66	9.00	

Heal th	Financial Systems	JASPER COUNTY HOS	PI TAL		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provi der		Period:	Worksheet S-1	
					From 01/01/2015		
					To 08/31/2015	Date/Time Pre 8/15/2016 3:5	
		· · I					
						1.00	
	Uncompensated and indigent care cost comput						
1.00	Cost to charge ratio (Worksheet C, Part I I	ine 202 column 3 divi	ded by lir	ne 202 column	8)	0. 644168	1.00
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid					1, 207, 091	2.00
3.00	Did you receive DSH or supplemental payment					Y	3.00
4.00	If line 3 is "yes", does line 2 include all			rom Medicaid	?	N 1 051 000	4.00
5.00	If line 4 is "no", then enter DSH or supple	emental payments from	Medicaid			1, 351, 333	5.00
6.00	Medicaid charges					2, 812, 659	6.00 7.00
7.00 8.00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs fo	r Modicaid program (	ino 7 minu	c cum of lin	a 2 and E. if	1, 811, 825 0	8.00
0.00	<pre>&lt; zero then enter zero)</pre>	medicard program (i			es z anu b, TT	0	0.00
	State Children's Health Insurance Program (	SCHLP) (see instructi	ons for ea	nch line)			
9.00	Net revenue from stand-al one SCHIP					0	9.00
	Stand-al one SCHIP charges					0	
11.00	5	0)				0	
12.00	Difference between net revenue and costs fo	or stand-alone SCHIP (	line 11 mi	nus line 9;	f < zero then	0	12.00
	enter zero)						
	Other state or local government indigent ca						
	Net revenue from state or local indigent ca					0	
14.00	Charges for patients covered under state or	local indigent care	program (N	Not included	n lines 6 or	0	14.00
45 00							45 00
	State or local indigent care program cost (		ant orro	program (Lip	15 minus line	0	
16.00	Difference between net revenue and costs fo 13; if < zero then enter zero)	state of Tocal Thu	gent care	program (TTh	e is minus line	0	16.00
	Uncompensated care (see instructions for ea	ch line)				I	
17.00	Private grants, donations, or endowment inc		ding chari	tv care		0	17.00
18.00	5		5	2		0	
19.00	Total unreimbursed cost for Medicaid, SCHI				s (sum of lines	0	19.00
	8, 12 and 16)		5	1 3			
				Uni nsured	Insured	Total (col. 1	
			-	patients	patients	+ col. 2)	
00.00				1.00	2.00	3.00	00.00
20.00	Total initial obligation of patients approv charges excluding non-reimbursable cost cen			130, 91	0 0	130, 910	20.00
21.00	Cost of initial obligation of patients appr			84, 32	з о	8/ 328	21.00
21.00	times line 20)	oved for charty care	(THE T	04, 32		04, 320	21.00
22.00	Partial payment by patients approved for ch	arity care			0 0	0	22.00
	Cost of charity care (line 21 minus line 22			84, 32	3 0	84, 328	23.00
				·			
						1.00	
24.00	Does the amount in line 20 column 2 include			nd a length o	fstay limit	N	24.00
	imposed on patients covered by Medicaid or						
	If line 24 is "yes," charges for patient d			ogram's lengt	n of stay limit	0	
	Total bad debt expense for the entire hospi					2, 296, 954	
	Medicare bad debts for the entire hospital	1	,			141, 516	
	Non-Medicare and non-reimbursable Medicare				20)	2, 155, 438	
	Cost of non-Medicare and non-reimbursable M		nse (line	i times line	20)	1, 388, 464	
30.00	Cost of uncompensated care (line 23 column Total unreimbursed and uncompensated care c		o 30)			1, 472, 792 1, 472, 792	
51.00	Listar and ellipsi sea and ancompensated calle c	ose (inte is plus Illi	5 50)			1,412,192	1 31.00

NLOLA.	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		HOSPI TAL Provi der		eriod: rom 01/01/2015	u of Form CMS-: Worksheet A	2002 10
					o 08/31/2015	Date/Time Pre 8/15/2016 3:5	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		1, 784, 496	1, 784, 496	71, 859	1, 856, 355	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 897, 484		0	2, 897, 484	
5.00	00500 ADMINISTRATIVE & GENERAL	1, 631, 632	2, 820, 562		-115, 358	4, 336, 836	
7.00	00700 OPERATION OF PLANT	162, 518	510, 912			673, 430	
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	40, 729 252, 301	21, 958		0	62, 687 325, 541	8.00 9.00
10.00	01000 DI ETARY	214, 810	73, 240 161, 633		0	193, 861	
11.00	01100 CAFETERIA	0	0	0	182, 582	182, 582	
13.00	01300 NURSING ADMINISTRATION	108, 595	1, 452		0	110, 047	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	12, 419	7,024		0	19, 443	
15.00 16.00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	247, 145 200, 648	1, 193, 653 47, 346			1, 440, 798 247, 994	
17.00	01700 SOCIAL SERVICE	200, 048	47, 340		29, 920	30, 644	
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	812, 462	85, 326			883, 857	
31.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	430, 257	20, 161 0	450, 418	-4, 109	446, 309 0	•
41.00	04200 SUBPROVIDER - TRF	0	0	0	0	0	
43.00	04300 NURSERY	0	0	0	0	0	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	364, 468	750, 623		-174	1, 114, 917	50.00
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0 680, 639	0 678, 794	0 1, 359, 433	0 -31, 814	0 1, 327, 619	
57.00	05700 CT SCAN	000, 039	078, 794	1, 359, 433	-31, 814	1, 327, 019	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60.00	06000 LABORATORY	487, 334	576, 607		0	1, 063, 941	60.00
60. 01 63. 00	06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	0 67, 722	0 67, 722	0	0 67, 722	
65.00	06500 RESPI RATORY THERAPY	580, 547	80, 483		-974	660, 056	
66.00	06600 PHYSI CAL THERAPY	719, 671	162, 028		-420, 501	461, 198	
66.01	06601 KV HEALTH PT	0	0	0	417, 070	417, 070	
67.00 67.01	06700 OCCUPATIONAL THERAPY 06701 KV HEALTH OT	0	0	0	288, 575 96, 413	288, 575 96, 413	
68.00	06800 SPEECH PATHOLOGY	0	0		93, 206	93, 206	•
68.01	06801 KV HEALTH ST	0	0	0	85, 373	85, 373	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	134, 385	134, 385	
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0	25, 358 0	25, 358 0	
75.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	/ 3.00
88. 00	08800 RURAL HEALTH CLINIC	120, 785	83, 117			203, 902	88. 00
88.03	08801 RURAL HEALTH CLINIC IV	146, 540	72, 476			219, 016	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	425 024	0 124, 544	-	0	0 480, 940	
90.00	09100 EMERGENCY	435, 924 613, 849	783, 333			1, 367, 969	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	010,017	, 00, 000	1,0,7,102	277210	1,007,707	92.00
93.00	04040 FAMILY PRACTICE	0	0	0	0	0	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	D10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	934, 997	122, 416	1, 057, 413	-103, 684	953, 729	101.00
116.00	D 11600 HOSPI CE	0	167, 741	167, 741	103, 684	271, 425	116.00
118.00		9, 198, 270	13, 295, 855			23, 040, 682	
	NONREI MBURSABLE COST CENTERS	1		l .	1		
	D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN D 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0		190.00 192.00
	1 19201 RENSSELAER HEALTH CENTER	0	0		0		192.00
	19300 NONPALD WORKERS	0	0	0	0		193.00
194.00	07950 ALTERNACARE	315, 318	11, 868	327, 186	0	327, 186	194.00
	07951 DME EQUI PMENT	0	0	0	0		194.01
	2 07952 KV HEALTH CENTER 3 07957 ST. JOE HEALTH CENTER	569, 471 46, 940	99, 063 19, 107		-560, 136	108, 398 66, 047	
	407957 ST. JOE HEALTH CENTER 407953 FOUNDATION	40, 940	19, 107		20, 784	20, 784	
	507954 MEALS ON WHEELS	0	0	0	20, 704	0	194.05
194.06	607955 WATER LAB	26, 865	17, 337			44, 202	194.06
	7 07956 ADVERTI SI NG	13, 377	30, 731		-7, 205	36, 903	194.07
194. 07 200. 00		10, 170, 241	13, 473, 961	23, 644, 202	0	23, 644, 202	000 -

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	JASPER COUNT F EXPENSES	TY HOS		CCN: 151324	In Lie Period:	u of Form CMS-25 Worksheet A	552-10
RECENS					0000. 101021	From 01/01/2015 To 08/31/2015		bared:
	Cost Center Description	Adjustments	Not	Expenses			8/15/2016 3:56	
	cost center bescription		For A	<u>Ilocation</u> 7.00				
	GENERAL SERVICE COST CENTERS							
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	-96, 033 -71, 945		1, 760, 322 2, 825, 539				1.00 4.00
5.00	00500 ADMINI STRATI VE & GENERAL	-1, 381, 236		2,955,600				5.00
7.00	00700 OPERATION OF PLANT	0		673, 430				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0		62, 687				8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0 -34, 109		325, 541 159, 752				9.00 10.00
	01100 CAFETERI A	-252		182, 330				11.00
	01300 NURSI NG ADMI NI STRATI ON	0		110, 047				13.00
	01400 CENTRAL SERVICES & SUPPLY	0		19, 443				14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	-27, 473 -9, 524	1	1, 413, 325 238, 470				15.00 16.00
	01700 SOCIAL SERVICE	-7, 324		30, 644				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS							
	03000 ADULTS & PEDIATRICS	-6, 425		877, 432				30.00
	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	-1, 500 0		444, 809 0				31.00 41.00
	04200 SUBPROVI DER	0		0				42.00
43.00	04300 NURSERY	0		0				43.00
F0 00	ANCI LLARY SERVICE COST CENTERS			050, 204				F0 00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	-255, 533 0		859, 384 0				50.00 52.00
	05400 RADI OLOGY-DI AGNOSTI C	-5,800		1, 321, 819				54.00
57.00	05700 CT SCAN	0		0				57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0				58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0		0 1, 063, 941				59.00 60.00
60.01	06001 BLOOD LABORATORY	0		1,003,741				60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		67, 722				63.00
	06500 RESPIRATORY THERAPY	0		660, 056				65.00
66. 00 66. 01	06600 PHYSI CAL THERAPY 06601 KV HEALTH PT	-1, 546 0		459, 652 417, 070				66. 00 66. 01
67.00	06700 OCCUPATI ONAL THERAPY	0		288, 575				67.00
67.01	06701 KV HEALTH OT	0		96, 413				67.01
68.00	06800 SPEECH PATHOLOGY	0		93, 206				68.00
68. 01 70. 00	06801 KV HEALTH ST 07000 ELECTROENCEPHALOGRAPHY	0		85, 373 0				68. 01 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-476		133, 909				71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0		25, 358				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0				73.00
88 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	-4, 280		199, 622				88.00
	08801 RURAL HEALTH CLINIC IV	0	1	219, 016				88.03
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0				89.00
	09000 CLINIC 09100 EMERGENCY	25, 891- 900-	1	455, 049 1, 367, 069				90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	- 700		1, 307, 009				92.00
	04040 FAMILY PRACTICE	0		0				93.00
101 00	OTHER REIMBURSABLE COST CENTERS			050 700	1			101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	1	953, 729			/'	101.00
116.00	11600 HOSPI CE	0		271, 425			1	116.00
118.00		-1, 922, 923	2	1, 117, 759			1	118.00
100 00	NONREI MBURSABLE COST CENTERS			0				100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0		0				190.00 192.00
	19201 RENSSELAER HEALTH CENTER	0		0				192.00
193.00	19300 NONPALD WORKERS	0		0				193.00
	07950 ALTERNACARE	0		327, 186				194.00
	07951 DME EQUIPMENT 07952 KV HEALTH CENTER			0 108, 398				194. 01 194. 02
	esserve nenenn venten	0		66, 047				194.02
194. 02 194. 03	07957 ST. JOE HEALTH CENTER	0	1	00, 047				
194. 02 194. 03 194. 04	07953 FOUNDATI ON	0		20, 784			1	194.04
194. 02 194. 03 194. 04 194. 05	07953 FOUNDATION 07954 MEALS ON WHEELS			20, 784 0	-		1	194. 04 194. 05
194.02 194.03 194.04 194.05 194.06	07953 FOUNDATI ON			20, 784			1  1  1	194. 04 194. 05 194. 06 194. 07

Hool th	Financial Systems		JASPER COUNT			ln lia	eu of Form CMS-2552-10
	SI FI CATI ONS		JASELK COUNT		CCN: 151324	Peri od:	Worksheet A-6
RECLAS	STELCATIONS			PLOVEDEL	CCN. 151524	From 01/01/2015	
						To 08/31/2015	Date/Time Prepared:
							8/15/2016 3:56 pm
		Increases					
	Cost Center	Line #	Salary	Other			
	2.00	3.00	4.00	5.00			
	A – CAFETERIA						
1.00	CAFETERI A	<u>11.</u> 00	<u> </u>	7 <u>8, 3</u> 95			1.00
	0		104, 187	78, 395			
	B - HOSPICE			-			
1.00	HOSPICE	<u> </u>	103, 684	0			1.00
	0		103, 684	0			
	D - CHARGEABLE SUPPLIES	74.00		450 740			
1.00	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	159, 743			1.00
0.00	PATI ENTS	0.00					
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			7.00
			0	159, 743			
	E - KV CENTER RECLASS		055 070	(1.000			
1.00	KV HEALTH PT	66.01	355, 270	61, 800			1.00
2.00	KV HEALTH OT	67.01	82, 127	14, 286			2.00
3.00	KV_HEALTH_ST	<u></u>	72, 723	<u> </u>			3.00
	0		510, 120	88, 736			
	F - ADVERTISING	=	0.405	5 000			
1.00	ADMI NI STRATI VE & GENERAL	5.00	2, 185	<u>5, 020</u>			1.00
	0		2, 185	5, 020			
	G - PROPERTY INSURANCE	1.00	a	74.050			
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	71, 859			1.00
	FIXT	+	— — — <sub>0</sub>				
			0	71, 859			
1 00	H - REHAB RECLASS	(7.00	274 424	14 140			1.00
1.00 2.00	OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	67.00 68.00	274, 426 88, 636	14, 149 4, 570			1.00
3.00	KV_HEALTH_CENTER	<u> </u>	36, 822	<u>1, 898</u> 20, 617			3.00
	U I – IMPLANTABLE DEVICES		399, 884	20, 617			
1.00	I - IMPLANTABLE DEVICES	72.00	0	25 250			1, 00
1.00	PATIENT	72.00	0	25, 358			1.00
	PATIENT	+		25, 358			
	J - SOCIAL SERVICE RECLASS		U	25, 556			
1.00	SOCIAL SERVICE RECLASS	17.00	29, 920	0			1,00
1.00			<u>29, 920</u> 29, 920	0			1.00
	K - FOUNDATION RECLASS		29, 920	0			
1.00	FOUNDATION RECLASS	194.04		20, 784			1.00
1.00		194.04	<u>0</u>	2 <u>0, 784</u> 20, 784			1.00
500 00	Grand Total: Increases		1, 149, 980	470, 512			500.00
500.00		I	1, 147, 700	470, 312			1 500.00

alth Financial Systems		JASPER COUNTY				u of Form CMS-2552
CLASSI FI CATI ONS			Provi der	CCN: 151324	Period: From 01/01/2015 To 08/31/2015	Worksheet A-6 Date/Time Prepare 8/15/2016 3:56 pt
	Decreases					
Cost Center	Line #	Salary	Other	Wkst. A-7 Ret	f.	
6. 00	7.00	8.00	9.00	10.00		
A – CAFETERIA						
00 DI ETARY	10.00	104, 187	78, 395		0	1
0		104, 187	78, 395			
B - HOSPICE						
00 HOME HEALTH AGENCY	101.00	103, 684	0		0	1
0		103, 684	ō			
D - CHARGEABLE SUPPLIES						
00 ADULTS & PEDIATRICS	30.00	0	13, 931		0	1
00 INTENSIVE CARE UNIT	31.00	0	4, 109		0	2
00 OPERATING ROOM	50.00	0	174		0	3
00 RADI OLOGY-DI AGNOSTI C	54.00	0	31, 814		0	4
00 RESPI RATORY THERAPY	65.00	0	974		0	5
OO CLINIC	90.00	0	79, 528		0	6
00 EMERGENCY	91.00	0	29, 213		0	7
0		0	159, 743			
E - KV CENTER RECLASS						
00 KV HEALTH CENTER	194.02	510, 120	88, 736		0	1
00	0.00	0	0		0	2
00	0.00	0	0		0	3
0 — — — — — —		510, 120	88, 736			
F - ADVERTISING						
00 ADVERTI SI NG	194.07	2, 185	5, 020		0	1
0		2, 185	5, 020			
G - PROPERTY INSURANCE						
00 ADMI NI STRATI VE & GENERAL	5.00	0	7 <u>1, 8</u> 59		12	1
0		0	71, 859			
H – REHAB RECLASS	I			1		
00 PHYSI CAL THERAPY	66.00	399, 884	20, 617		0	1
00	0.00	0	0		0	2
00	0.00	0	0		0	3
0		399, 884	20, 617			
I - IMPLANTABLE DEVICES				r		
00 MEDI CAL SUPPLI ES CHARGED TO	71.00	0	25, 358		0	1
PATI ENTS	$\square$ $\square$ $\square$					
0		0	25, 358			
J - SOCIAL SERVICE RECLASS				1		
00 ADMI NI STRATI VE & GENERAL	5.00	2 <u>9, 9</u> 20	0	L	Q	1
0		29, 920	0	l		
K - FOUNDATION RECLASS				1		
00 ADMI NI STRATI VE & GENERAL	5.00	0	2 <u>0, 7</u> 84		Q	1
0		0	20, 784			
0.00 Grand Total: Decreases		1, 149, 980	470, 512			500

	Financial Systems	JASPER COUNT					u of Form CMS-2	
RECONC	LLIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151324	Per Fro To	iod: m 01/01/2015 08/31/2015		pared:
				Acqui si ti or	IS			
		Begi nni ng Bal ances	Purchases	Donati on		Total	Disposals and Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	53, 965	0		0	0	0	1.00
2.00	Land Improvements	1, 859, 740	0		0	0	0	2.00
3.00	Buildings and Fixtures	22, 406, 327	0		0	0	0	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	10, 924, 832	2, 687, 187		0	2, 687, 187	69, 152	5.00
6.00	Movable Equipment	0	0		0	0	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	35, 244, 864	2, 687, 187		0	2, 687, 187	69, 152	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	35, 244, 864	2, 687, 187		0	2, 687, 187	69, 152	10.00
		Endi ng Bal ance						
			Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	53, 965	0					1.00
2.00	Land Improvements	1, 859, 740	0					2.00
3.00	Buildings and Fixtures	22, 406, 327	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	13, 542, 867	0					5.00
	Movable Equipment	0	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	37, 862, 899	0					8.00
	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	37, 862, 899	0					10.00

Heal th	Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	1	Period: From 01/01/2015 To 08/31/2015		pared:
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	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 WOR	KSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1,042,842	3, 633	414, 58	4 0	0	1.00
3.00	Total (sum of lines 1-2)	1,042,842	3, 633	414, 58	4 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	1			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR						
1.00	NEW CAP REL COSTS-BLDG & FIXT	323, 437	1, 784, 496				1.00
3.00	Total (sum of lines 1-2)	323, 437	1, 784, 496				3.00

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 To 08/31/2015		
	COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col	instructions)	Insurance	
	1.00		2)		5.00	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	37, 862, 899	0	37, 862, 89	9 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	37, 862, 899		37, 862, 89			1.00 3.00
		TION OF OTHER (			F CAPITAL	3.00
	ALLUCA			JUNIMART	I CAFITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS			1		
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	-		0 946, 809		1.00
3.00 Total (sum of lines 1-2)	0	Ů		0 946, 809	3, 633	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	-	74.050	1		1 7/0 000	
1.00 NEW CAP REL COSTS-BLDG & FIXT	414, 584			0 323, 437		1.00
3.00  Total (sum of lines 1–2)	414, 584	71, 859	1	0 323, 437	1, 760, 322	3.00

403051	MENTS TO EXPENSES				Period: From 01/01/2015 To 08/31/2015		pared:
				Expense Classification of To/From Which the Amount is		8/15/2016 3:5	<u>o pm</u>
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - NEW CAP	1.00	2.00	3.00 NEW CAP REL COSTS-BLDG &	4.00	5.00	1.00
	REL COSTS-BLDG & FIXT (chapter 2)			FIXT			
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2.00
. 00	Investment income - other		0		0.00	0	3.00
. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
	suppliers (chapter 8)		0				
. 00	Telephone services (pay stations excluded) (chapter		U		0.00	0	7.00
3. 00	21) Television and radio service		0		0.00	0	8.00
. 00	(chapter 21) Parking lot (chapter 21)		O		0.00	0	9,00
0.00	Provider-based physician adjustment	A-8-2	0			0	10.00
1.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
2.00	(chapter 23) Related organization	A-8-1	0			0	12.00
3. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
4.00 5.00	Cafeteria-employees and guests Rental of quarters to employee		0		0.00 0.00	0	14.00
	and others		U				
6. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
7.00	patients Sale of drugs to other than		0		0.00	0	17.00
8.00	patients Sale of medical records and	В	0 524	MEDICAL RECORDS & LIBRARY	16.00		
	abstracts	D	- 7, 324	MEDICAL RECORDS & LIDRART			
9.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
0.00	Vending machines Income from imposition of		0		0.00		
	interest, finance or penalty charges (chapter 21)					_	
2.00	Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
4.00	therapy costs in excess of	A-0-3	U	INSIGAL MERALI	00.00		24.00
25.00	limitation (chapter 14) Utilization review –		0	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation (chapter 21)						
6. 00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
7.00	Depreciation - CAP REL		0	*** Cost Center Deleted ***	2.00	0	27.00
8. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
9.00 0.00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00		29.00 30.00
	therapy costs in excess of		Ū				
0. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
1.00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						
2.00	CAH HIT Adjustment for	А	-81, 658	NEW CAP REL COSTS-BLDG &	1.00	9	32.00
3. 00	Depreciation and Interest WELLNESS PROGRAM FEE	В	-1,546	FI XT PHYSI CAL THERAPY	66.00	о	33.00

Health Financial Systems		JASPER COUNT	Y HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	
				From 01/01/2015	Data (Tima Daa	
				To 08/31/2015	Date/Time Pre 8/15/2016 3:5	
			Expense Classification o	n Worksheet A		
			To/From Which the Amount is			
Cost Center Description Ba	asis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4,00	5.00	
34.00 MEALS ON WHEELS	B	-34, 109		10.00		34.00
35.00 MISCELLANEOUS INCOME BENEFITS	B		EMPLOYEE BENEFITS DEPARTMEN			
36.00 MI SCELLANEOUS I NCOME ADMI N	В		ADMI NI STRATI VE & GENERAL	5.00		36.00
38.00 MI SCELLANEOUS I NCOME PHARMACY	В	-27, 473	PHARMACY	15.00	0	38.00
39.00 MI SCELLANEOUS SUPPLI ES	В	-476	MEDICAL SUPPLIES CHARGED TO	71.00	0	39.00
			PATI ENTS			
40.00 MISCELLANEOUS INCOME CLINIC	В		RURAL HEALTH CLINIC	88.00		
41.00 MI SCELLANEOUS I NCOME CARE	В	-24, 191		90.00		
42.00 CAFETERIA	А		CAFETERIA	11.00		
43.00 INTEREST INCOME	A		ADMI NI STRATI VE & GENERAL	5.00		
44.00 LOBBYING EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		1
45. 00 GOODWILL AMORTIZATION	A		NEW CAP REL COSTS-BLDG & FIXT	1.00	9	45.00
45.01 ANESTHESIA OFFSET	А		ADULTS & PEDIATRICS	30.00	0	45.01
45. 02 ANESTHESIA OFFSET	A		INTENSIVE CARE UNIT	31.00		
45. 03 ANESTHESIA OFFSET	A		OPERATING ROOM	50.00		
45. 04 ANESTHESIA OFFSET	A		RADI OLOGY-DI AGNOSTI C	54.00		
45. 05 ANESTHESIA OFFSET	A	-1, 700		90.00		
45.06 ANESTHESIA OFFSET	A		EMERGENCY	91.00		
45.07 HAF OFFSET	А	-397,063	ADMI NI STRATI VE & GENERAL	5.00		
45.08 AUDIT ADJUSTMENTS OFFSET	Α	-665, 000	ADMINISTRATIVE & GENERAL	5.00	0	45.08
45.09		0		0.00	0	45.09
45. 10		0		0.00		
45. 11		0		0.00		
45. 12		0		0.00	0	1 101 12
50.00 TOTAL (sum of lines 1 thru 49)		-1, 922, 923				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(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.

Heal th I	Financial Syste	ems	JASPER COUN	TY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provi der		Period: From 01/01/2015 To 08/31/2015	Date/Time Pre	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	8/15/2016 3:5 Physi ci an/Prov	
	WKSt. A LINE #	I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		LABORATORY	10, 000					
2.00		EMERGENCY	406, 250				-	
3.00	0.00		0			0 0	0	3.00
4.00	0.00		0	0	(	0 0	0	4.00
5.00	0.00		0	0	(	0 0	0	5.00
6.00	0.00		0	0	(	0 0	0	6.00
7.00	0.00		0	0	(	0 0	0	7.00
8.00	0.00		0	0	(	0 0	0	8.00
9.00	0.00		0	0	(	0 0	0	9.00
10.00	0.00		0	0		0 0	0	10.00
200.00			416, 250	0	416, 250		0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	60.00	LABORATORY	0	0	(	0 0	0	1.00
2.00	91.00	EMERGENCY	0	0	(	o o	0	2.00
3.00	0.00		0	0		o o	0	3.00
4.00	0.00		0			o o	0	4.00
5.00	0.00		0	0		o l	0	5.00
6.00	0, 00		0	0		0 0	0	6,00
7.00	0.00		0	0	(		0	7.00
8.00	0.00		0	0	(	0	0	
9.00	0.00		0			-	-	
10.00	0.00		0			0	-	
200.00	0.00		0	0		-	-	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200100
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	60.00	LABORATORY	0	0	(	0 0		1.00
2.00	91.00	EMERGENCY	0	0	(	0 0		2.00
3.00	0.00		0	0	(	0 0		3.00
4.00	0.00		0	0	(	o o		4.00
5.00	0.00		0			0 0		5.00
6.00	0.00		0					6.00
7.00	0.00		0					7.00
8.00	0.00		0					8.00
9.00	0.00		0					9,00
10.00	0.00		0					10.00
200.00	5.00		0					200.00
	I	1	1 0		1		I	

UISIL	IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151324	Period: From 01/01/2015 To 08/31/2015		pared:
					Physical Therapy		
						1.00	
	PART I - GENERAL INFORMATION						
. 00 2. 00	Total number of weeks worked (excluding aide: Line 1 multiplied by 15 hours per week	s) (see Instruc	tions)			34 510	1.00 2.00
3.00	Number of unduplicated days in which supervis	sor or therapis	t was on provi	der site (se	e instructions)	0	3.00
ł. 00	Number of unduplicated days in which therapy		on provider si	te but neith	er supervisor	0	4.00
5.00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe		anists (see in	structions)		0	5.00
b. 00	Number of unduplicated offsite visits - there				by therapy	0	6.00
	assistant and on which supervisor and/or the	rapist was not	present during	the visit(s	)) (see		
. 00	instructions) Standard travel expense rate					5.51	7.00
3.00	Optional travel expense rate per mile					0.00	•
		Supervi sors	Therapi sts	Assi stants	Ai des 4.00	Trai nees 5.00	
9.00	Total hours worked	1.00 0.00	2.00	3.00	4.00	0.00	9.00
0.00	AHSEA (see instructions)	0.00	79.90	0.	00 0.00		
1.00	Standard travel allowance (columns 1 and 2,	39.95	39.95	0.	00		11.00
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)						
2.00	Number of travel hours (provider site)	0	о		0		12.00
2.01	Number of travel hours (offsite)	0	0		0		12.01
3. 00 3. 01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		13.00 13.0
5. 01			0		0		13.0
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
4.00	Supervisors (column 1, line 9 times column 1,	line 10)				0	14.0
5.00	Therapists (column 2, line 9 times column 2,	line 10)				177, 778	15.0
6.00	Assistants (column 3, line 9 times column 3,			1: 14	1/ 6	0	16.0
7.00	Subtotal allowance amount (sum of lines 14 allothers)	na 15 tor respi	ratory therapy	or lines 14	-16 TOP ALL	177, 778	17.0
8.00	Aides (column 4, line 9 times column 4, line	10)				0	18.0
9.00	Trainees (column 5, line 9 times column 5, li				- · · · · · · · · · · · · · · · · · · ·	0	19.0
20.00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory					177, 778	20.00
	occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete			<u> </u>	1 1 0 1' 0	0.00	
21.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3,	•	5	m of columns	1 and 2, Tine 9	0.00	21.00
22.00	Weighted allowance excluding aides and train					0	22.00
23.00	Total salary equivalency (see instructions)					177, 778	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	VANCE AND TRAVE	L EXPENSE COMPL	UTATION - PR	OVIDER SITE		
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00	Subtotal (line 24 for respiratory therapy or					0	26.00
27.00	Standard travel expense (line 7 times line 3 others)	for respirator	y therapy or s	um or lines	3 and 4 for all	0	27.00
28.00	Total standard travel allowance and standard	travel expense	at the provid	er site (sum	of lines 26 and	0	28.00
	27) Optional Travel Allowance and Optional Travel	Evnense					
29.00	Therapists (column 2, line 10 times the sum		d 2, line 12 )			0	29.0
30.00	Assistants (column 3, line 10 times column 3,					0	30. 0
31.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column:				w an aum of	0	31.0
32.00	columns 1-3, line 13 for all others)	s i and z, i i ne	13 TOF TESPIT	atory therap	y or sum of	0	32.00
	Standard travel allowance and standard travel	expense (line	28)			0	33.00
3. 00		expense (sum				0	34.0
84.00	Optional travel allowance and standard trave			d 32)		0	35.00
	Optional travel allowance and optional trave	expense (sum			VICES OUTSIDE PRO	WIDER SITE	
84.00		expense (sum			VICES OUTSIDE PRO	OVIDER SITE	
34.00 35.00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11)	expense (sum			VICES OUTSIDE PRO	0	
34.00 35.00 36.00 37.00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	expense (sum			VICES OUTSIDE PRO	0	37.0
34.00 35.00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	expense (sum	EXPENSE COMPU		VICES OUTSIDE PRO	0	37.0 38.0
4.00 5.00 6.00 7.00 8.00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	expense (sum ANCE AND TRAVEL	EXPENSE COMPU		VICES OUTSIDE PRO	0 0 0	37. 0 38. 0
<ul> <li>34.00</li> <li>35.00</li> <li>36.00</li> <li>37.00</li> <li>38.00</li> <li>39.00</li> <li>40.00</li> </ul>	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the suu Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	expense (sum NCE AND TRAVEL m of lines 5 an Expense D1 times column	EXPENSE COMPU		VICES OUTSIDE PRO	0 0 0 0	36.00 37.00 38.00 39.00 40.00
<ul> <li>34.00</li> <li>35.00</li> <li>36.00</li> <li>37.00</li> <li>38.00</li> <li>39.00</li> <li>40.00</li> <li>41.00</li> </ul>	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	expense (sum NCE AND TRAVEL m of lines 5 an Expense D1 times column	EXPENSE COMPU		VICES OUTSIDE PRO	0 0 0 0	37.00 38.00 39.00 40.00 41.00
<ul> <li>4. 00</li> <li>5. 00</li> <li>6. 00</li> <li>7. 00</li> <li>8. 00</li> <li>9. 00</li> <li>0. 00</li> <li>1. 00</li> <li>2. 00</li> </ul>	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12, 0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	expense (sum NCE AND TRAVEL m of lines 5 an Expense D1 times column n 3, line 10)	EXPENSE COMPU d 6) 2, line 10)		VICES OUTSIDE PRO	0 0 0 0	37.00 38.00 39.00 40.00 41.00 42.00
<ul> <li>4. 00</li> <li>5. 00</li> <li>6. 00</li> <li>7. 00</li> <li>8. 00</li> <li>9. 00</li> <li>40. 00</li> </ul>	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	expense (sum NCE AND TRAVEL n of lines 5 an Expense D1 times column n 3, line 10) n of columns 1-	EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	TATION - SER		0 0 0 0 0 0 0 0 0 0	37.00 38.00 39.00 40.00
4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	expense (sum NCE AND TRAVEL m of lines 5 an Expense D1 times column n 3, line 10) m of columns 1- Dffsite Service	EXPENSE COMPU d 6) 2, line 10) 3, line 13.01) s; Complete one	E of the fol	lowing three line	0 0 0 0 0 0 0 0 25 44, 45,	37.0 38.0 39.0 40.0 41.0 42.0

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	JASPER COUNTY FURNI SHED BY			In Lie Period: From 01/01/2015 To 08/31/2015 Physical Therapy	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 8/15/2016 3:50 Cost	-3 pared:
					nysrear merapy		
6 00	Optional travel allowance and optional travel	expense (sum of	Flines 12 an	d 13 - see in	structions)	1.00	46.00
10.00	optional travel arrowance and optional travel	Therapists	Assi stants	Ai des	Trai nees	Total	40.00
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.0	0 0.00	0.00	47. OC
8.00	Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.00
9.00	Total overtime (including base and overtime	0.00	0.00	0.0	0.00		49. OC
	allowance) (multiply line 47 times line 48)						
	CALCULATION OF LIMIT				- 1		
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.0	0 0.00	0.00	50. OC
1.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0 0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
2.00	Adjusted hourly salary equivalency amount	79. 90	0.00	0.0	0 0.00		52.00
3. 00	(see instructions) Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.00
4. 00	Maximum overtime cost (enter the lesser of	О	0		0 0		54.00
5. 00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply	о	0		0 0		55.00
6. 00	line 47 times line 52) Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	o	0		o o	0	56.00
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST A	DJUSTMENT				
	Salary equivalency amount (from line 23)					177, 778	
	Travel allowance and expense - provider site			<b>`</b>		0	58.00
	Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56)	es (from lines 4	14, 45, OF 46	)		0	59.0
0.00	Equipment cost (see instructions)					0	60. 0 61. 0
						0	
						-	
2.00	Supplies (see instructions) Total allowance (sum of lines 57-62)						
2. 00 3. 00	Total allowance (sum of lines 57-62)	vour records)				177, 778	
2.00 3.00 4.00			enter zero)			88, 889	64.0
2.00 3.00 4.00 5.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63	- if negative,		II others		88, 889 0	64. 0 65. 0
2.00 3.00 4.00 5.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	sum of lines 24	and 25 for a		others	88, 889 0 0	64. 00 65. 00 100. 00
2.00 3.00 4.00 5.00 00.00 00.01	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27	sum of lines 24	and 25 for a		others	88, 889 0 0 0 0	64. 0 65. 0 100. 0
2.00 3.00 4.00 5.00 00.00 00.01 00.02	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	s - if negative, sum of lines 24 therapy or sum	and 25 for a of lines 3 a	nd 4 for all		88, 889 0 0 0 0 0	64. 00 65. 00 100. 00 100. 0 100. 0
2.00 3.00 4.00 5.00 00.00 00.01 00.02 01.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	sum of lines 24 therapy or sum	and 25 for a of lines 3 a of lines 3 a	nd 4 for all		88, 889 0 0 0 0 0 0	64. 00 65. 00 100. 00 100. 0 100. 0
2.00 3.00 4.00 5.00 00.00 00.01 00.02 01.00 01.01	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or	sum of lines 24 therapy or sum	and 25 for a of lines 3 a of lines 3 a	nd 4 for all		88, 889 0 0 0 0 0 0 0 0	64. 00 65. 00 100. 0 100. 0 100. 0 101. 0 101. 0
2.00 3.00 4.00 5.00 00.00 00.01 00.02 01.00 01.01	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	sum of lines 24 therapy or sum	and 25 for a of lines 3 a of lines 3 a	nd 4 for all		88, 889 0 0 0 0 0 0 0 0	64. 00 65. 00 100. 0 100. 0 100. 0 101. 0 101. 0
2.00 3.00 4.00 5.00 00.00 00.01 00.02 01.00 01.01 01.02	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 24 therapy or sum therapy or sum sum of lines 29	and 25 for a of lines 3 a of lines 3 a and 30 for a	nd 4 for all nd 4 for all II others		88, 889 0 0 0 0 0 0 0 0 0	64. 00 65. 00 100. 00 100. 02 100. 02 101. 00 101. 02
3.00 4.00 5.00 00.01 00.02 01.00 01.01 01.02 02.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or	sum of lines 24 therapy or sum therapy or sum sum of lines 29 sum of lines 29	and 25 for a of lines 3 a of lines 3 a and 30 for a and 30 for a	nd 4 for all nd 4 for all II others II others	others	88, 889 0 0 0 0 0 0 0 0 0 0 0 0	64. 00 65. 00 100. 0 100. 0 100. 0 101. 0 101. 0 101. 0 102. 00
2.00 3.00 4.00 5.00 00.00 00.01 00.02 01.00 01.01 01.02 02.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 24 therapy or sum therapy or sum sum of lines 29 sum of lines 29	and 25 for a of lines 3 a of lines 3 a and 30 for a and 30 for a	nd 4 for all nd 4 for all II others II others	others	88, 889 0 0 0 0 0 0 0 0 0 0 0 0	64. 00 65. 00 100. 00 100. 02 100. 02 101. 00 101. 02

	Financial Systems NLLOCATION - GENERAL SERVICE COSTS	JASPER COUNT			eriod: rom 01/01/2015		
			CAPITAL			8/15/2016 3:5	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	
		0	1.00	4.00	4A	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	1, 760, 322	1, 760, 322				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 825, 539		2, 825, 539			4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	2, 955, 600		445, 604	3, 586, 688		1
7.00	00700 OPERATION OF PLANT	673, 430		45, 151	749, 567	148, 251	7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	62, 687 325, 541		11, 315 70, 095	100, 853 427, 419	19, 947 84, 536	8.00 9.00
10.00	01000 DI ETARY	159, 752		30, 734	223,000		•
11.00	01100 CAFETERI A	182, 330		28, 946	241, 897	47, 843	•
13.00	01300 NURSI NG ADMI NI STRATI ON	110,047		30, 170	146, 909	29,056	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	19, 443 1, 413, 325		3, 450 68, 663	22, 893 1, 498, 726	4, 528 296, 421	14.00 15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	238, 470		55, 745	316, 882		•
17.00	01700 SOCI AL SERVI CE	30, 644		8, 312	40, 500		•
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	077.400	1/0 /7/	005 704	1 070 /00	054 700	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	877, 432 444, 809		225, 721 119, 536	1, 272, 629 576, 899	251, 703 114, 100	
41.00	04100 SUBPROVIDER - IRF	444, 809		0	570, 899 0	114, 100   0	
42.00	04200 SUBPROVI DER	0	-	0	0	0	•
43.00	04300 NURSERY	0	0	0	0	0	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	050, 204	100 4/5	101 250	1 151 107	227.770	
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	859, 384	190, 465	101, 258	1, 151, 107 0	227,668	50.00 52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 321, 819	159, 812	189, 098	1, 670, 729	330, 433	
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 063, 941	40, 916	135, 393	0 1, 240, 250	0 245, 299	
60.00	06001 BLOOD LABORATORY	1,003,941	40, 910	0	1, 240, 230	0	60.01
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	67, 722	3, 321	0	71, 043	14, 051	63.00
65.00	06500 RESPI RATORY THERAPY	660, 056		161, 290	875, 115	173, 082	65.00
66. 00 66. 01	06600 PHYSI CAL THERAPY 06601 KV HEALTH PT	459, 652 417, 070		88, 845 98, 703	589, 396 653, 201	116, 572 129, 191	66. 00 66. 01
67.00	06700 OCCUPATIONAL THERAPY	288, 575		76, 242	395, 886	78, 299	•
67.01	06701 KV HEALTH OT	96, 413			150, 996		•
68.00	06800 SPEECH PATHOLOGY	93, 206			127, 861	25, 289	•
68. 01 70. 00	06801 KV HEALTH ST 07000 ELECTROENCEPHALOGRAPHY	85, 373		20, 204	133, 707	26, 445	
		133, 909		0	152, 790	0 30 219	70.00
	07200 I MPL. DEV. CHARGED TO PATIENT	25, 358		0	27, 832	5, 505	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
88.00	OUTPATIENT SERVICE COST CENTERS	100 622	0	33, 557	233, 179	46 110	
88.00	08801 RURAL HEALTH CLINIC IV	199, 622 219, 016		40, 712	303, 733		
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00	09000 CLI NI C	455, 049		121, 110	650, 668	128, 690	•
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 367, 069	74, 127	170, 542	1, 611, 738	318, 773	91.00 92.00
92.00 93.00	04040 FAMILY PRACTICE	0	0	0	0	0	•
	OTHER REIMBURSABLE COST CENTERS	-					1
101.00	10100 HOME HEALTH AGENCY	953, 729	51, 245	230, 959	1, 235, 933	244, 445	101.00
11/ 00	SPECIAL PURPOSE COST CENTERS	271 425	4 125	20.00(	204.244	(0.100	11/ 00
118.00	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117)	271, 425 21, 117, 759		28, 806 2, 687, 603	304, 366 20, 784, 392		116.00 118.00
110.00	NONREI MBURSABLE COST CENTERS	21,117,707	1,001,071	2,007,000	20, 101, 072	0, 101, 007	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 819	0	3, 819		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
	19201 RENSSELAER HEALTH CENTER 19300 NONPAID WORKERS			0	0		192. 01 193. 00
	07950 ALTERNACARE	327, 186	138, 856	87, 603	553, 645	109, 501	
194.01	07951 DME EQUI PMENT	0	0	0	0	0	194. 01
	07952 KV HEALTH CENTER	108, 398		26, 719	174, 107		194.02
	07957 ST. JOE HEALTH CENTER	66, 047 20, 784		13, 041	79, 088		194. 03 194. 04
	07953 FOUNDATION 07954 MEALS ON WHEELS	20, 784		0 0	20, 784 0		194.04
	07955 WATER LAB	44, 202	9, 199	7, 464	60, 865		194.06
194.07	07956 ADVERTI SI NG	36, 903	4, 567	3, 109	44, 579	8, 817	194. 07
200.00			_	_	0	_	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2015 To 08/31/2015		pared: 6 pm
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS NEW BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT		ADMI NI STRATI VE & GENERAL	
202.00 TOTAL (sum lines 118-201)	0 21, 721, 279	1.00 1,760,322	4.00 2,825,53	4A 9 21, 721, 279	5.00 3,586,688	202 00
202.00   10TAL (Suil THES 118-201)	21, 721, 279	1,700,322	2, 020, 03	9 21, 721, 279	3, 300, 000	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	JASPER COUNT			eri od:	u of Form CMS-: Worksheet B	2552-10
				Fr	com 01/01/2015 08/31/2015	Part I Date/Time Pre 8/15/2016 3:5	epared:
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	
		PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS		- 				
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	897, 818					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	15, 615					8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	18, 483 18, 908			288, 346		9.00
11.00	01100 CAFETERI A	17, 807	0	1, 340	200, 010	308, 887	
13.00	01300 NURSING ADMINISTRATION	3, 892	0	0	0	4, 101	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	9, 734 13, 182		6, 230 0	0	9, 089 13, 971	
17.00	01700 SOCI AL SERVI CE	898		-	0	1, 612	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	98, 558			116, 158	53, 453	
31.00 41.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	7, 301	5, 643	10, 598 0	13, 299 0	16, 832 0	
42.00	04200 SUBPROVI DER	0	0	0	0	0	
43.00	04300 NURSERY	0	0	0	0	0	43.00
	ANCI LLARY SERVICE COST CENTERS	110 7/0	10.70/		a	10.050	50.00
50.00 52.00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	110, 762	10, 796	0	0	18, 858 0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	92, 938	0		0	30, 379	
57.00	05700 CT SCAN	0	0	0	0	0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	23, 795		0 28, 866	0	0 25, 941	59.00 60.00
60.00	06001 BLOOD LABORATORY	0	0	20,000	0	23, 741	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 931	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	31, 269			0	27, 485	
66. 00 66. 01	06600 PHYSICAL THERAPY 06601 KV HEALTH PT	23, 785 79, 920		13, 224	0	14, 056 0	
67.00	06700 OCCUPATI ONAL THERAPY	18, 068		10, 042	0	12,063	
67.01	06701 KV HEALTH OT	18, 474		0	0	0	
68.00	06800 SPEECH PATHOLOGY	5, 833		3, 242	0	3, 896	
68. 01 70. 00	06801 KV HEALTH ST 07000 ELECTROENCEPHALOGRAPHY	16, 359 0	0	0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 980	0	0	0	1, 606	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 439		0	0	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
88.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	88. 00
	08801 RURAL HEALTH CLINIC IV	25, 591	0	0	0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90.00	09000 CLINIC	43, 330			3, 820	19, 277	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	43, 108	17, 095	37, 231	0	30, 960	91.00
	04040 FAMILY PRACTICE	0	0	0	0	0	
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	29, 801	0	26, 508	0	0	101.00
116 00	SPECIAL PURPOSE COST CENTERS	2, 405	0	0	0	0	116.00
118.00		784, 166			133, 277	283, 579	
	NONREI MBURSABLE COST CENTERS				· · ·		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 221	0	0	0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19201 RENSSELAER HEALTH CENTER	0		0	0		192.00 192.01
	19300 NONPALD WORKERS	0	0	0	0		193.00
194.00	07950 ALTERNACARE	80, 751	19, 315	93, 325	130, 017	23, 115	194.00
	07951 DME EQUI PMENT	0	0	0	0		194.01
	07952 KV HEALTH CENTER 07957 ST. JOE HEALTH CENTER	22,674	0	0	0		194. 02 194. 03
	07957 ST. JOE HEALTH CENTER 07953 FOUNDATION			0	0		194. 0.
94.04	07954 MEALS ON WHEELS	0	0	0	25, 052		194.05
		F 050	0	4, 641	0	1, 457	194.00
194.05 194.06	07955 WATER LAB	5, 350			-		
94.05  94.06  94.07	07956 ADVERTI SI NG	5, 350 2, 656		0	0		194. 07
194.05 194.06	07956 ADVERTISING Cross Foot Adjustments			0	0	736	194.07 200.00 201.00

JUSIA	LLOCATION - GENERAL SERVICE COSTS		Y HOSPITAL Provider	CCN: 151324	Period:	u of Form CMS- Worksheet B	2002-1
					From 01/01/2015 To 08/31/2015	Part I	epared: 56 pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	RECORDS & LI BRARY	SOCIAL SERVICE	
	CENEDAL SEDVICE COST CENTEDS	13.00	14.00	15.00	16.00	17.00	
. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 5.00 7.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						4.00 5.00 7.00
8.00 9.00 0.00 1.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA						8.00 9.00 10.00 11.00
3.00	01300 NURSI NG ADMI NI STRATI ON	183, 958					13.00
	01400 CENTRAL SERVICES & SUPPLY	0	27, 421				14.00
5.00		0	0	1, 820, 20			15.0
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0		0 406, 709 0 0	51, 020	16.0 17.0
7.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0		0 0	51,020	1 17.0
80.00	03000 ADULTS & PEDIATRICS	57, 380	0		0 117, 108	46, 611	30.00
	03100 INTENSIVE CARE UNIT	18, 069	0		0 0	4, 409	
	04100 SUBPROVIDER - IRF	0	0		0 0	0	
2.00 3.00	04200 SUBPROVI DER 04300 NURSERY	0	0		0 0	0	
3.00	ANCI LLARY SERVICE COST CENTERS	0	0		0 0	0	43.0
0.00	05000 OPERATI NG ROOM	20, 244	0		0 42, 799	0	50.0
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
4.00	05400 RADI OLOGY-DI AGNOSTI C	32, 612	0		0 84, 977	0	
7.00 8.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	57.0 58.0
9.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.0
D. 00	06000 LABORATORY	0	0		0 9, 904	0	60. C
0. 01	06001 BLOOD LABORATORY	0	0		0 0	0	
3.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0		0 0	0	63.0
5.00 6.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0		0 0	0	
6.01	06601 KV HEALTH PT	0	0		0 0	0	
7.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67. C
7.01	06701 KV HEALTH OT	0	0		0 0	0	67. C
8.00 8.01	06800 SPEECH PATHOLOGY 06801 KV HEALTH ST	0	0		0 0	0	68. C
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 725	27, 421		0 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	
3.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1, 820, 20	0 00	0	73. C
0 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 0
	08801 RURAL HEALTH CLINIC IV	0	0		0 0	0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
	09000 CLINIC	20, 693	0		0 94, 670	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	33, 235	0		0 57, 251	0	91.0
	04040 FAMILY PRACTICE	0	0		0 0	0	
	OTHER REIMBURSABLE COST CENTERS		-	<u> </u>	-, -,		
01.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101. C
1/ 00	SPECIAL PURPOSE COST CENTERS		0			0	1110 0
18.00	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117)	0 183, 958	0 27, 421	1, 820, 20	0 0 00 406, 709		116.0
10.00	NONREI MBURSABLE COST CENTERS	103, 730	27, 421	1, 020, 20		51, 020	
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192. 0
	19201 RENSSELAER HEALTH CENTER	0	0		0 0		192.0
	19300 NONPAI D WORKERS 07950 ALTERNACARE	0	0				193. C
	07951 DME EQUI PMENT	0	0		0 0		194.0
	07952 KV HEALTH CENTER	0	0		0 0		194.0
	07957 ST. JOE HEALTH CENTER	0	0		0 0		194. 0
	07953 FOUNDATION	0	0		0 0		194.0
	07954 MEALS ON WHEELS 07955 WATER LAB	0	0				194. C
	07955 WATER LAB	0	0				194.0
00.00			0		, U		200. 0
01.00	Negative Cost Centers	0	0		0 0		201.0
202.00	TOTAL (sum lines 118-201)	183, 958	27, 421	1, 820, 20	00 406, 709	51, 020	1202 0

Health Financial Systems COST ALLOCATION - GENER		JASPER COUNT		dor C	CN: 151324	Period:	u of Form CMS-2552- Worksheet B
COST ALLOCATION - GENER	AL SERVICE CUSIS		PLOVI	der ci	GN: 151324	From 01/01/2015 To 08/31/2015	Part I Date/Time Prepare
Cost Center	Description	Subtotal	Intern 8	2	Total		8/15/2016 3:56 pm
			Residents (		rotar		
			& Post Stepdowr				
			Adj ustmen				
		24.00	25.00		26.00		
. 00 00100 NEW CAP REL	OST CENTERS COSTS-BLDG & FIXT			-			1.
	NEFITS DEPARTMENT						4.
5. 00 00500 ADMI NI STRAT							5.
7.00 00700 OPERATION 0 3.00 00800 LAUNDRY & L							7.
9.00 00900 HOUSEKEEPIN							9.
10. 00 01000 DI ETARY							10.
1.00 01100 CAFETERIA 3.00 01300 NURSING ADM	INISTRATION						11.
4.00 01400 CENTRAL SER							13.
5.00 01500 PHARMACY							15.
16.00 01600 MEDICAL REC 17.00 01700 SOCIAL SERV							16. 17.
	SERVICE COST CENTERS						17.
30. 00 03000 ADULTS & PE	DI ATRI CS	2, 288, 619		0	2, 288, 6	19	30.
31. 00 03100 I NTENSI VE C		767, 150 0		0	767, 1	50 0	31.
12. 00 04200 SUBPROVIDER		0		0		0	41.
43. 00 04300 NURSERY		0		0		0	43.
ANCI LLARY SERVICE		1 502 224		o	1 500 0	24	50.
50.00 05000 OPERATING R 52.00 05200 DELIVERY R0		1, 582, 234		0	1, 582, 23	0	52.
54. 00 05400 RADI OLOGY-D		2, 300, 010		0	2, 300, 01	10	54.
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RE	SONANCE LMACING (MDL)	0		0		0	57. 58.
59. 00 05900 CARDI AC CAT	SONANCE IMAGING (MRI) HETERIZATION	0		0		0	58. 59.
50. 00 06000 LABORATORY		1, 574, 055		0	1, 574, 0	55	60.
50. 01 06001 BLOOD LABOR		0		0	07.0	0	60.
53. 00 06300 BLOOD STORI 55. 00 06500 RESPI RATORY	NG, PROCESSING & TRANS. THERAPY	87, 025 1, 130, 973		0	87, 02 1, 130, 9		63. 65.
66. 00 06600 PHYSI CAL TH	ERAPY	768, 712		0	768, 7		66.
56. 01 06601 KV HEALTH P 57. 00 06700 OCCUPATI ONA		862, 312 514, 358		0	862, 3 <sup>-</sup> 514, 3		66. 67.
57.01 06701 KV HEALTH 0		199, 334		0	199, 3		67.
58.00 06800 SPEECH PATH		166, 121		0	166, 12		68.
58. 01 06801 KV HEALTH S 70. 00 07000 ELECTROENCE		176, 511		0	176, 51	0	68. 70.
	PLIES CHARGED TO PATIENTS	224, 741		0	224, 74		70.
2.00 07200 IMPL. DEV.	CHARGED TO PATIENT	34, 776		0	34, 7	76	72.
3.00 07300 DRUGS CHARG		1, 820, 200		0	1, 820, 20	00	73.
OUTPATIENT SERVIC 38.00 08800 RURAL HEALT		279, 298		0	279, 29	98	88.
38.03 08801 RURAL HEALT	H CLINIC IV	389, 397		0	389, 39		88.
89. 00 08900 FEDERALLY Q 20. 00 09000 CLINIC	UALIFIED HEALTH CENTER	0 968, 910		0	968, 9 <sup>.</sup>	0	89. 90.
21.00 09100 EMERGENCY		2, 149, 391		0	2, 149, 39		90.
2. 00 09200 OBSERVATI ON	BEDS (NON-DISTINCT PART)			0			92.
23. 00 04040 FAMILY PRAC OTHER REIMBURSABL		0		0		0	93.
01. 00 10100 HOME HEALTH		1, 536, 687		0	1, 536, 68	37	101.
SPECIAL PURPOSE C	OST CENTERS						
116.0011600 HOSPI CE 118.00 SUBTOTALS (	SUM OF LINES 1-117)	366, 969		0	366, 90		116. 118.
NONREI MBURSABLE		20, 187, 783		U	20, 187, 78	55	110.
90.00 19000 GIFT, FLOWE	R, COFFEE SHOP & CANTEEN	6, 795		0	6, 79	95	190.
92. 00 19200 PHYSI CI ANS' 92. 01 19201 RENSSELAER		0		0		0	192. 192.
93. 00 19300 NONPALD WOR		0		0		0	192.
94.0007950 ALTERNACARE		1, 009, 669		0	1, 009, 60	59	194.
94. 01 07951 DME EQUI PME 94. 02 07952 KV HEALTH C		0		0	001 O	0	194. 194.
94. 02 07952 KV HEALTH C 94. 03 07957 ST. JOE HEA		231, 216 94, 730		0	231, 2 <sup>-</sup> 94, 7:		194.
94. 04 07953 FOUNDATI ON		24, 895		0	24, 89	95	194.
94. 05 07954 MEALS ON WH	EELS	25,052		0	25, 0		194.
94.06 07955 WATER LAB 94.07 07956 ADVERTI SING		84, 351 56, 788		0	84, 35 56, 78		194. 194.
200.00 Cross Foot		0		o	50, 70	0	200.
201.00 Negative Co	st Centers	0		0	o. = -	0	201.
202.00 TOTAL (sum	lines 118-201)	21, 721, 279		0	21, 721, 21	/9	202.

Local Centrer Benedription         Directly Related and the second and the seco		Financial Systems TION OF CAPITAL RELATED COSTS	JASPER COUNT		Fr	eriod: com 01/01/2015	u of Form CMS-2 Worksheet B Part II	
Description         Description <thdescription< th=""> <thdescription< th=""></thdescription<></thdescription<>		Cost Center Description	Assigned New Capital Related Costs	RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI VE & GENERAL	6 pm
4.00         00400[SPLICYLE BRENT IS DEPARTMENT         C         0         0         4.00         0         4.00         0         4.00         0         4.00         0         4.00         0         0         4.00         0		GENERAL SERVICE COST CENTERS	0	1.00	211	1.00	0.00	
0.00         00000         000000         000000         000000000000000000000000000000000000	4.00 5.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0 0 0	185, 484	185, 484	0		4.00 5.00
14.00         0         0         0         0         0         0         224         14.00           15.00         01500         HECABLS & LIBARAY         0         16.738         10.738         0         15.30         15.30         15.30         15.30         15.30         15.33         16.00         15.33         16.00         15.34         17.00           10.00         01000 AULI IS & FUDA IN ICS.         0         1.544 <td>9.00 10.00 11.00</td> <td>00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A</td> <td>000000000000000000000000000000000000000</td> <td>31, 783 32, 514 30, 621</td> <td>31, 783 32, 514 30, 621</td> <td>0 0 0</td> <td>4, 372 2, 281 2, 474</td> <td>9.00 10.00 11.00</td>	9.00 10.00 11.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A	000000000000000000000000000000000000000	31, 783 32, 514 30, 621	31, 783 32, 514 30, 621	0 0 0	4, 372 2, 281 2, 474	9.00 10.00 11.00
Impart FMT FOUT HE SERVICE COST CENTERS         0         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         1         0         1         0         1         0	14.00 15.00 16.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY		0 16, 738 22, 667	0 16, 738 22, 667	0 0 0	234 15, 329 3, 241	14.00 15.00 16.00
30. 00         3300 ADULTS & PEDLATELCS         0         160, 476         160, 476         0         13, 076         30. 00           41. 00         01100 INTENSIVE CARE UNIT         0         12, 554         0         5, 901         31. 00           41. 00         01400 SUBERVO DER - 1 RF         0         <	17.00		0	1, 344	1, 344	0		17.00
43. 00         0 43200 HURSERY         0         0         0         0         43. 00           MOLLARY SERVICE COST CENTERS         0         190, 465         0         11, 774         50. 00           05000 DELVERY ROOM         0         0         0         0         0         0         0         52. 00           50. 00         05000 DELVERY ROOM         0         0         0         0         57. 00         57. 00         57. 00         57. 00         57. 00         57. 00         57. 00         57. 00         56. 00         0         0         0         0         0         56. 00         56. 00         0         0         0         0         0         0         0         0         0         0         0         0         56. 00         0	31. 00 41. 00	03000 ADULTS & PEDIATRICS 03100 I NTENSIVE CARE UNIT 04100 SUBPROVIDER - I RF	000000000000000000000000000000000000000	12, 554	12, 554 0	0	5, 901 0	31.00 41.00
ANCI LARY SERVICE COST CENTRES         0         10        <			0	0		-	-	
52.00         OSSOO DELL'ERY ROOM & LABOR ROOM         0			1	1				
64. 00         065400         RADILOCY-DIACNOSTIC         0         159, 812         0         17, 087         64. 00         57.00         057.00         057.00         057.00         057.00         057.00         057.00         057.00         057.00         057.00         057.00         057.00         0 <th< td=""><td></td><td></td><td>0</td><td>190, 465</td><td></td><td></td><td></td><td></td></th<>			0	190, 465				
57.00         05700         CT SCAM         0         0         0         0         0         0         57.00           59.00         05600         CARDIAC CATHETER LATION         0         0         0         0         58.00         05600         CARDIAC CATHETER LATION         0         0         0         0         58.00         05600         CARDIAC CATHETER LATION         0				159 812	-	-	-	1
99         00         00         0			0	0		-		
60. 00         00000         LABORATORY         0         40, 916         0         12, 685         60. 00         0			0	0	0	0	0	1
60         0	59.00		0	0	0	0	0	59.00
63:00         06:300         BLOOD STORING, PROCESSING & TRANS.         0         3.3:21         3.3:21         0         7.27         63:00           65:00         06:00         PROCESSING & THERAPY         0         53:769         05:769         06:00         65:00         65:00         66:00         66:01			0	40, 916	40, 916	0		1
65.00         0c500         REST PATORY         THERAPY         0         53.769         53.769         0         8,951         65.00           66.00         0c600         PHS1 CAL THERAPY         0         137,428         137,428         0         6,681         6,01           67.00         0c701         RV HEALTH PT         0         31,766         0         1,37,428         0         4,049         67.00           67.01         0c701         RV HEALTH OT         0         31,766         0         1,308         68.00           66.01         0c600         SPECCH PATHOLOGY         0         10.030         1,308         68.00           70.00         07000         MEDICAL SUGGRAPHY         0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>			0	0	0	0		
66.00         0e600         PHYSICAL THERAPY         0         40.99         40.899         40.899         0         6.028         6.6         00           66.01         06601         KV HEALTH PT         0         137,428         0         6.61         66.00           67.00         06700         0CCUPATI ONAL THERAPY         0         31,766         0         4.049         6.70           67.00         06701         KV HEALTH OT         0         31,766         0         1.544         67.01           68.00         06800         SPECH PATHOLOCY         0         10.030         0         1,368         88.00           66.01         0         07000         ELECTROENCEPHALOCRAPHY         0         28.130         0         1,366         68.01           71.00         07100         MEDICAL SUPPLIES CHARGE TO PATIENTS         0         0         0         0         71.00           72.00         07300         DRUBCS CHARED TO PATIENTS         0         0         0         0         0         72.00           073.00         DRUBCS CHARED TO PATIENTS         0         0         0         0         0         72.00           073.00         DRUGC RURAL HEALTH CLINIC			0					1
66.01         0c601 KV HEALTH PT         0         137,428         137,428         137,428         0         6,611         6         01           67.00         0c700 OCCUPATIONAL THERAPY         0         31,069         31,069         0         40,09         67.00           68.00         0c800 SPEECH PATHOLOGY         0         10,030         0         1,308         68.00           68.01         0c8001 KV HEALTH ST         0         128,130         0         13.66         81.00           70.00         07000 KEDICAL SUGGRAPHY         0						-		1
67:00       06700       0CCUPATI ONAL THERAPY       0       31,069       31,069       0       4,049       67.00         67:01       067.01       068.01       SPEECH PATHOLOGY       0       10,030       10,030       0       1,544       67.01         68:00       06800       SPEECH PATHOLOGY       0       10,030       10,030       0       1,308       68.01         00       0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td>1</td>			0					1
68.00         06800         SPECH PATHOLOGY         0         10.030         10.030         10.030         1.308         68.01         68.01           66.01         06001         V HEALTH ST         0         28.130         28.130         28.130         0         1.368         68.01         70.00           70.00         07100         MEDICAL         SUPPLIES CHARGED TO PATIENTS         0         0         0         0         0         0         72.00         73.00         72.00         73.00         72.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00			0			0		
68.01         Constraint         0         28, 130         28, 130         28, 130         0         1, 368         66. 01         Constraint           00         07000         LECTRORNEPHAL CRARPHY         0	67.01	06701 KV HEALTH OT	0	31, 766	31, 766	0	1, 544	67.01
70.00         0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>-</td> <td></td> <td>1</td>			0			-		1
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       18,881       18,881       0       1,563       71.00         72.00       07300       IMPL. DEV. CHARGED TO PATIENT       0       2,474       2,474       0       285       72.00       <			0	28, 130		0		
72.00         07200         IMPL         DEV.         CHARGED TO PATLENT         0         2.474         2.474         0         285         72.00           0173.00         D7300         DRUGS CHARGED TO PATLENTS         0			0	18 881	-	0		
73.00         OPT300         DRUGS         CHARGED TO PATIENTS         O         O         O         O         73.00           DUTPATIENT SERVICE COST CENTERS         0         0         0         0         2,385         88.00         89.00         6.655         90.00         91.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00	72 00	07200 IMPL DEV CHARGED TO PATIENT						1
OUTPATLENT SERVICE COST CENTERS           88.00         OB800         RURAL HEALTH CLINIC         0         0         2,385         88.00           88.03         OB801         RURAL HEALTH CLINIC IV         0         44,005         0         3,107         88.00           89.00         OB900         FEDERALLY OUALIFIED HEALTH CENTER         0         0         0         0         89.00           90.00         O9000         CLINIC         0         74,509         0         6,655         91.00           91.00         O9100         EMERCENCY         0         74,127         0         16,455         91.00         92.00         92.00         93.00         4040         FAMILY PRACTICE         0         0         0         0         92.00         93.00         0         0         0         0         0         92.00         93.00         0         0         0         0         0         0         92.00         93.00         0         0         0         0         0         0         0         0         92.00         93.00         93.00         93.00         93.00         93.00         93.00         93.00         93.00         93.00         93.00         93.113.116	73.00	07300 DRUGS CHARGED TO PATIENTS	0			0		
88.03         08801         RURAL HEALTH CLINIC IV         0         44,005         44,005         0         3,107         88.03           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0         0         97.00         0         0         0         0         0         0         0         0         97.00         0								
89.00         08900         FEDERALLY         QUALIFIED HEALTH CENTER         0         74,509         74,509         0         6,655         90.00         92.00         0			0	0		0		
90.00         09000         CLINIC         0         74,509         74,509         74,509         0         6,655         90.00           91.00         09100         EMERGENCY         0         74,127         0         16,485         91.00         92.00         0928VATI 0N BEDS (NON-DI STINCT PART)         0         0         0         0         0         0         0         0         0         0         93.00         04040 [FAMI LY PRACTICE         0         0         0         0         0         0         0         0         0         93.00           0100         10100         HORE HEALTH AGENCY         0         51,245         0         12,641         10.00           10100         HORE HEALTH AGENCY         0         4,135         4,135         0         3,113         116.00           118.00         SUBTOTALS (SUM OF LINES 1-117)         0         1,564,891         0         175,900         18.00           190.00         IFVSI CLANS' PRIVATE OFFICES         0         0         0         0         0         192.00         192.01         192.01         192.01         192.01         192.01         192.01         192.01         192.01         192.01         192.01			0	44,005		0		
91.00       09100       EMERGENCY       0       74, 127       74, 127       0       16, 485       91.00       92.00       92.00       00404       FAIL LY PRACTICE       0       0       0       0       0       92.00<			0	74, 509	-	0		1
93.00         OddA040         FAMILY PRACTICE         0 <td>91.00</td> <td>09100 EMERGENCY</td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td> <td></td>	91.00	09100 EMERGENCY	0			0		
OTHER         REI MBURSABLE         COST         CENTERS           101.00         HORE         HEALTH         AGENCY         0         51, 245         51, 245         0         12, 641         101.00           SPECIAL         PURPOSE         COST         CENTERS         0         4, 135         0         3, 113         116.00           116.00         HOSPI CE         0         4, 135         4, 135         0         3, 113         116.00           118.00         SUBTOTALS         (SUM OF LINES 1-117)         0         1, 564, 891         1, 564, 891         0         37, 900         118.00           NONREI         MBURSABLE         COST CENTERS         0         0, 819         3, 819         0         0         100.00         192.00         192.00         192.00         192.00         192.00         0         0         0         0         192.00         192.00         192.00         192.00         192.00         192.00         192.00         192.00         0         0         0         0         192.00         192.01         192.01         192.01         192.01         192.01         192.01         192.01         192.01         192.01         192.01         192.01         192.01 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
101.00       10100       HOME       HEALTH       AGENCY       0       51, 245       51, 245       0       12, 641       101.00         SPECIAL PURPOSE COST CENTERS         116.00       11600       HOSPI CE       0       4, 135       4, 135       0       3, 113       116.00         116.00       SUBTOTALS (SUM OF LINES 1-117)       0       1, 564, 891       1, 564, 891       0       175, 90       118.00         NONREI IMBURSABLE COST CENTERS         190.00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       3, 819       0       391       190.00         192.01       19201       RENSELAER HEALTH CENTER       0       0       0       0       0       192.01         193.00       19300       NONPAI D       WORKERS       0       0       0       0       193.00         194.00       07950       ALTERNACARE       0       138, 856       138, 856       138, 856       194.00       0         194.02       07957       ST. JOE HEALTH CENTER       0       38, 990       38, 990       0       1, 781       194.04         194.02       07957       ST. JOE HEALTH CENTER       0	93.00		0	0	0	0	0	93.00
SPECIAL PURPOSE COST CENTERS           116.00         11500         HOSPICE         0         4,135         4,135         0         3,113         116.00           118.00         SUBTOTALS (SUM OF LINES 1-117)         0         1,564,891         1,564,891         0         175,900         118.00           NORREI MBURSABLE COST CENTERS         0         1,564,891         0         3,819         0         39         190.00         190.00         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         3,819         3,819         0         0         190.00         192.01         190.00         192.01         190.00         0         0         0         192.00         192.01         192.01         192.01         192.01         193.00         00         0         0         0         192.01           193.00         193.00         NORKERS         0         0         0         0         0         0         193.00           194.00         079550         ALTERNACARE         0         138,856         138,856         138,856         0         0         194.02         194.02         07957         37. JOE HEALTH CENTER         0         0         0         0         0         0         0	101 00		0	51 245	51 245	0	12 641	101 00
116.00       HOSPI CE       0       4, 135       4, 135       0       3, 113       116.00         118.00       SUBTOTALS (SUM OF LINES 1-117)       0       1, 564, 891       1, 564, 891       0       175, 900       118.00         NONRET MBURSABLE COST CENTERS         190.00       GIPCO       GIPCO       0       0       0       39       190.00         192.00       PHYSI CLANS' PRI VATE OFFICES       0       0       0       0       192.00         192.01       19200       PHYSI CLANS' PRI VATE OFFICES       0       0       0       0       192.00         192.01       19200       NONPAI D WORKERS       0       0       0       0       192.01         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         194.00       07950       ALTERNACARE       0       138, 856       138, 856       0       5, 663       194.00         194.02       07951       DME EQUI PMENT       0       38, 990       38, 990       0       1, 781       194.02         194.02       07955       KY HEALTH CENTER       0       0       0       0       194.03       194.04 <t< td=""><td></td><td>SPECIAL PURPOSE COST CENTERS</td><td></td><td>01/210</td><td>017210</td><td></td><td>12,011</td><td></td></t<>		SPECIAL PURPOSE COST CENTERS		01/210	017210		12,011	
190.00       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       3,819       3,819       0       39       190.00         192.00       19200       PHYSI CI ANS' PRI VATE OFFI CES       0       0       0       0       192.00         192.01       19201       RENSSELAER HEALTH CENTER       0       0       0       0       192.01         193.00       19300       NONPAI D WORKERS       0       0       0       0       193.00         194.00       07950       ALTERNACARE       0       138,856       138,856       0       5,663       194.00         194.00       07951       DME EQUI PMENT       0       0       0       0       0       194.00         194.02       07952       KV HEALTH CENTER       0       38,990       38,990       0       1,781       194.02         194.02       07957       ST. JOE HEALTH CENTER       0       0       0       0       201.03         194.04       07953       FOUNDATI ON       0       0       0       0       213.194.04         194.05       07954       MEALS ON WHEELS       0       0       0       0       213.194.04         194.06       07955       WAT		DI1600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)						
192.00       PHYSI CI ANS' PRI VATE OFFICES       0       0       0       192.00         192.01       19201       RENSSELAER HEALTH CENTER       0       0       0       0       192.01         193.00       19200       NONPAI D WORKERS       0       0       0       0       193.00         194.00       07950       ALTERNACARE       0       138,856       138,856       0       5,663       194.00         194.01       07951       DME EQUI PMENT       0       0       0       0       194.01         194.02       07952       KV HEALTH CENTER       0       38,990       0       1,781       194.02         194.03       07957       ST. JOE HEALTH CENTER       0       0       0       0       194.03         194.04       07953       FOUNDATI ON       0       0       0       0       201.00       194.04         194.04       07955       MEALS ON WHEELS       0       0       0       0       194.05         194.06       07955       WATER LAB       0       9,199       9,199       0       623       194.06         194.06       07955       WATER LAB       0       9,199       9,199 <td>190.00</td> <td></td> <td>0</td> <td>3, 819</td> <td>3, 819</td> <td>0</td> <td>39</td> <td>190. 00</td>	190.00		0	3, 819	3, 819	0	39	190. 00
193.00       19300       NONPAI D WORKERS       0       0       0       193.00         194.00       07950       ALTERNACARE       0       138,856       138,856       0       5,663       194.00         194.01       07951       DME EQUI PMENT       0       0       0       0       194.01         194.02       07952       KV HEALTH CENTER       0       38,990       0       1,781       194.02         194.03       07957       ST. JOE HEALTH CENTER       0       0       0       0       809       194.03         194.04       07953       FOUNDATI ON       0       0       0       0       2013       194.03         194.04       07953       FOUNDATI ON       0       0       0       0       213       194.03         194.04       07953       FOUNDATI ON       0       0       0       0       194.04         194.05       07954       MEALS ON WHEELS       0       0       0       0       194.05         194.06       07955       WATER LAB       0       9,199       9,199       0       623       194.06         194.06       07955       ADVERT LAB       0       4,56			0	0	0	0		
194.00       07950       ALTERNACARE       0       138,856       138,856       0       5,663       194.00         194.01       07951       DME EQUI PMENT       0       0       0       0       194.01         194.02       07952       KV HEALTH CENTER       0       38,990       38,990       0       1,781       194.02         194.03       07957       ST. JOE HEALTH CENTER       0       0       0       0       809       194.03         194.04       07953       FOUNDATI ON       0       0       0       0       213       194.04         194.05       07954       MEALS ON WHEELS       0       0       0       0       194.05         194.06       07955       WATER LAB       0       9,199       9,199       0       623       194.06         194.06       07955       ADVERTI SI NG       0       4,567       4,567       0       456       194.06         194.06       07955       ADVERTI SI NG       0       4,567       0       456       194.06         200.00       Cross Foot Adjustments       0       0       0       0       20.00         201.00       Negative Cost Centers			0	0	0	0		1
194.01       07951       DME EQUI PMENT       0       0       0       194.01         194.02       07952       KV HEALTH CENTER       0       38,990       38,990       0       1,781       194.02         194.03       07957       ST. JOE HEALTH CENTER       0       0       0       0       809       194.03         194.04       07953       FOUNDATI ON       0       0       0       213       194.04         194.05       07954       MEALS ON WHEELS       0       0       0       194.05         194.06       07955       WATER LAB       0       9, 199       9, 199       0       623       194.06         194.07       07956       ADVERTI SI NG       0       4, 567       4, 567       0       456       194.06       194.05         200.00       Cross Foot Adj ustments       0       0       0       0       0       201.00       0       0       0       0       201.00			0	120.05(	120.05(	0		
194.02       07952       KV HEALTH CENTER       0       38,990       38,990       0       1,781       194.02         194.03       07957       ST. JOE HEALTH CENTER       0       0       0       809       194.03         194.04       07953       FOUNDATION       0       0       0       0       213       194.04         194.05       07954       MEALS ON WHEELS       0       0       0       0       194.05         194.06       07955       WATER LAB       0       9,199       9,199       0       623       194.06         194.07       07956       ADVERTI SI NG       0       4,567       4,567       20.00       456       194.05         200.00       Cross Foot Adj ustments       0       0       0       0       201.00       0       0       0       0       201.00				130, 000	136, 630	0		
194.03       07957       ST. JOE HEALTH CENTER       0       0       0       809       194.03         194.04       07953       FOUNDATI ON       0       0       0       213       194.04         194.05       07954       MEALS ON WHEELS       0       0       0       0       194.05         194.06       07955       WATER LAB       0       0       0       0       194.05         194.06       07955       WATER LAB       0       9,199       9,199       0       623       194.06         194.07       07956       ADVERTI SI NG       0       4,567       4,567       0       450       194.06         200.00       Cross Foot Adj ustments       0       0       0       0       200.00       201.00       0       0       0       0       0       201.00			0	38, 990	38, 990	0		
194.05       07954       MEALS ON WHEELS       0       0       0       194.05         194.06       07955       WATER LAB       0       9,199       9,199       0       623       194.06         194.07       07956       ADVERTI SI NG       0       4,567       0       456       194.07         200.00       Cross Foot Adjustments       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       0       201.00	194.03	07957 ST. JOE HEALTH CENTER	0	0	0	0		
194.06       07955       WATER LAB       0       9, 199       9, 199       0       623       194.06         194.07       07956       ADVERTISING       0       4, 567       0       456       194.07         200.00       Cross Foot Adjustments       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       0			0	0	0	0		
194.07         07956         ADVERTISING         0         4,567         0         456         194.07           200.00         Cross Foot Adjustments         0         0         200.00			0	0	0	0		
200.00         Cross Foot Adjustments         0         200.00           201.00         Negative Cost Centers         0         0         0         0         0         0         201.00			0			0		
201.00         Negative Cost Centers         0         0         0         0         0         201.00				4, 507		0	400	
				0	0	0		201.00
	202.00	)   TOTAL (sum lines 118-201)	0	1, 760, 322	1, 760, 322	0	185, 484	202.00

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		eriod: Tom 01/01/2015	Worksheet B Part II	
			To	08/31/2015	Date/Time Pre 8/15/2016 3:5	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS		1	1			
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	38, 653					7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	672					8.00 9.00
10. 00 01000 DI ETARY	814		163	35, 772		10.00
11. 00 01100 CAFETERI A	767	C	93	0	33, 955	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	168		0	0	451	1
14. 00  01400  CENTRAL_SERVI CES & SUPPLY 15. 00  01500  PHARMACY	419		0 0 434	0	0 999	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	567		0	0	1, 536	
17.00 01700 SOCIAL SERVICE	39	C	0 0	0	177	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS	4,243	10, 938	15, 517	14, 411	5, 877	30.00
31. 00 03100 I NTENSI VE CARE UNI T	314			1, 650	1, 850	
41.00 04100 SUBPROVIDER - IRF	0			0	0	
42. 00  04200  SUBPROVI DER 43. 00  04300  NURSERY	0		-	0	0	1
ANCI LLARY SERVICE COST CENTERS	0		<u>y</u> 0	0	0	43.00
50. 00 05000 OPERATI NG ROOM	4,770	2, 260		0	2, 073	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		0 0	0	0 3, 339	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN	4,001		3, 346 0	0	3, 339	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	0	0	0	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C	0	0	0	
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	1,024		2,011	0	2, 852 0	60.00 60.01
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	83	-	-	0	0	1
65.00 06500 RESPI RATORY THERAPY	1, 346			0	3, 021	1
66. 00  06600  PHYSI CAL THERAPY 66. 01  06601  KV HEALTH PT	1,024 3,441		1	0	1, 545 0	
67.00 06700 OCCUPATIONAL THERAPY	778			0	1, 326	1
67.01 06701 KV HEALTH OT	795		0	0	0	67.01
68. 00 06800 SPEECH PATHOLOGY	251		226	0	428	
68. 01  06801 KV HEALTH ST 70. 00  07000 ELECTROENCEPHALOGRAPHY	704			0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	473		0	0	177	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	62		-	0	0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	C	0	0	0	73.00
88.00 08800 RURAL HEALTH CLINIC	0		0 0	0	0	88.00
88.03 08801 RURAL HEALTH CLINIC IV	1, 102		0	0	0	88.03
89. 00  08900  FEDERALLY QUALI FIED HEALTH CENTER 90. 00  09000  CLI NI C	1, 865			0 474	0 2, 119	
91. 00 09100 EMERGENCY	1,856			474	3, 403	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	0	C	0 0	0	0	93.00
101.00 10100 HOME HEALTH AGENCY	1, 283	C	1, 847	0	0	101.00
SPECIAL PURPOSE COST CENTERS		-	-	-		1
116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1-117)	104 33, 761			0 16, 535		116.00 118.00
NONREI MBURSABLE COST CENTERS	33,701	24, 312	. 50, 127	10, 335	51, 175	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	96		0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 RENSSELAER HEALTH CENTER	0	C	0	0		192.00 192.01
193. 00 19300 NONPALD WORKERS	0			0		192.01
194. 00 07950 ALTERNACARE	3, 476	4, 043	6, 501	16, 129	2, 541	194.00
194. 01 07951 DME EQUI PMENT	0	C C	0	0		194.01
194. 02 07952 KV HEALTH CENTER 194. 03 07957 ST. JOE HEALTH CENTER	976		0	0		194.02 194.03
194. 04 07953 FOUNDATI ON	0		0	0		194.03
194.0507954 MEALS ON WHEELS	0	C	0	3, 108	0	194.05
194.06 07955 WATER_LAB	230		323	0		194.06
194.07 07956 ADVERTISING 200.00  Cross Foot Adjustments	114		, 0	0	81	194.07 200.00
201.00 Negative Cost Centers	0	C	0	0		201.00
202.00   TOTAL (sum lines 118-201)	38, 653	28, 555	36, 951	35, 772	33, 955	202.00

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		eriod: rom 01/01/2015	Worksheet B Part II	
				08/31/2015		
Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCI AL SERVI CE	
	ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
	13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT						5.00 7.00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERIA						11.00
13.00 01300 NURSING ADMINISTRATION	8, 814	224			- 	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0	234 0	33, 919			14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0	C	28, 011		16.00
17. 00 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	C	0	2, 174	17.00
30. 00 03000 ADULTS & PEDI ATRI CS	2, 749	0			1, 986	
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF	866	0		0	188 0	31.00 41.00
42. 00 04200 SUBPROVI DER	0	0	C	0	0	42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	C	0	0	43.00
50.00 05000 OPERATING ROOM	970	0	C	2, 948	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		-	0	52.00
54. 00  05400  RADI OLOGY-DI AGNOSTI C 57. 00  05700  CT SCAN	1, 563 0	0		5, 853 0	0	54.00 57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	0		0 682	0	59.00 60.00
60. 01 06001 BLOOD LABORATORY	0	0	C	0	0	60.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 65. 00 06500 RESPI RATORY THERAPY	0	0	0	0	0	63.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
66. 01 06601 KV HEALTH PT	0	0	C	0	0	66.01
67.00 06700 OCCUPATI ONAL THERAPY 67.01 06701 KV HEALTH OT	0	0		0	0	67.00 67.01
68.00 06800 SPEECH PATHOLOGY	0	0	C	0	0	68.00
68. 01 06801 KV HEALTH ST 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	68.01 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	83	234	C	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	72.00 73.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	33, 919	0	0	73.00
88.00 08800 RURAL HEALTH CLINIC	0	0	C	0	0	1
88.03 08801 RURAL HEALTH CLINIC IV 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	88.03 89.00
90. 00 09000 CLINIC	991	0	C	6, 520		90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	1, 592	0	C	3, 943	0	91.00 92.00
93. 00 04040 FAMILY PRACTICE	0	0	C	0	0	1
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	0	0	C	0	0	101.00
SPECIAL PURPOSE COST CENTERS						1
116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1-117)	0 8, 814	0 234				116. 00 118. 00
NONREI MBURSABLE COST CENTERS	0,014	234	33, 919	20,011	2,174	116.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 RENSSELAER HEALTH CENTER	0	0		0		192. 00 192. 01
193. 00 19300 NONPAI D WORKERS	0	0	C	0	0	193.00
194. 00 07950  ALTERNACARE 194. 01 07951  DME_EQUI PMENT	0	0		0		194. 00 194. 01
194.0207952 KV HEALTH CENTER	0	0	c c	0	0	194. 02
194.03 07957 ST. JOE HEALTH CENTER	0	0	0	0		194.03
194.04 07953 FOUNDATION 194.05 07954 MEALS ON WHEELS	0	0		0		194. 04 194. 05
194.0607955WATER LAB	0	0	C	0	0	194.06
194.07 07956 ADVERTISING 200.00  Cross Foot Adjustments	0	0	C	0	0	194. 07 200. 00
201.00 Negative Cost Centers	0	0	C	0		201.00
202.00   TOTAL (sum lines 118-201)	8, 814	234	33, 919	28, 011	2,174	202.00

alth Financial Systems LOCATION OF CAPITAL RELATED CO	272	JASPER COUNT			CCN: 151324	Period:	eu of Form CMS-255 Worksheet B
LOCATION OF CAPITAL RELATED CO	313		FIU	viuei (	JCN. 131324	From 01/01/2015 To 08/31/2015	5 Part II
Cost Conton Decorint	ion	Subtotal	Inton		Tatal		8/15/2016 3:56 p
Cost Center Descript	1011	Subtotal	Interi Resident:		Total		
			& Pos				
			Stepdo Adjustm				
		24.00	25.0		26.00		
GENERAL SERVICE COST CENTE							
00 00100 NEW CAP REL COSTS-BL 00 00400 EMPLOYEE BENEFITS DE							1
00 00500 ADMINISTRATIVE & GEN							Ę
00 00700 OPERATION OF PLANT							
00 00800 LAUNDRY & LINEN SERV	'I CE						8
00 00900 HOUSEKEEPI NG . 00 01000 DI ETARY							10
. 00 01000 DI ETARY . 00 01100 CAFETERI A							10
. 00 01300 NURSI NG ADMI NI STRATI	ON						13
. 00 01400 CENTRAL SERVICES & S	UPPLY						14
. 00 01500 PHARMACY	DADY						15
. 00 01600 MEDICAL RECORDS & LI . 00 01700 SOCIAL SERVICE	BRARI						16
INPATIENT ROUTINE SERVICE	COST CENTERS						
. 00 03000 ADULTS & PEDI ATRI CS		246, 278		0	246, 2	78	30
. 00 03100 I NTENSI VE CARE UNI T		25, 242		0	25, 2		31
. 00 04100 SUBPROVIDER - IRF . 00 04200 SUBPROVIDER		0		0		0	41
. 00 04300 NURSERY		0		0		0	43
ANCILLARY SERVICE COST CEN	ITERS	-				- 1	
. 00 05000 OPERATING ROOM	5 5001	215, 260		0	215, 2		50
. 00 05200 DELIVERY ROOM & LABO . 00 05400 RADIOLOGY-DIAGNOSTIC		0 197, 076		0	197, 0	0	52
. 00 05700 CT SCAN		197,078		0	197, 0	0	57
. 00 05800 MAGNETIC RESONANCE I	MAGING (MRI)	0		0		0	58
. 00 05900 CARDI AC CATHETERI ZAT	ION	0		0		0	59
. 00 06000 LABORATORY		60, 170		0	60, 1	70	60
. 01 06001 BLOOD LABORATORY . 00 06300 BLOOD STORING, PROCE	SSING & TRANS	4, 131		0	4, 1	31	60
. 00 06500 RESPI RATORY THERAPY		69, 034		Ő	69, C		65
. 00 06600 PHYSI CAL THERAPY		52, 862		0	52, 8		66
. 01 06601 KV HEALTH PT		147, 550		0	147, 5		66
. 00 06700 OCCUPATIONAL THERAPY . 01 06701 KV HEALTH OT		37, 922 34, 105		0	37, 9 34, 1		67
. 00 06800 SPEECH PATHOLOGY		12, 243		0	12, 2		68
.01 06801 KV HEALTH ST		30, 202		0	30, 2		68
. 00 07000 ELECTROENCEPHALOGRAP		0		0	04.4	0	70
. 00 07100 MEDICAL SUPPLIES CHA . 00 07200 IMPL. DEV. CHARGED T		21, 411 2, 821		0	21, 4 2, 8		71
. 00 07300 DRUGS CHARGED TO PAT		33, 919		0	33, 9		73
OUTPATIENT SERVICE COST CE							
. 00 08800 RURAL HEALTH CLINIC		2, 385		0	2, 3		88
. 03 08801 RURAL HEALTH CLINIC . 00 08900 FEDERALLY QUALIFIED		48, 214		0	48, 2	0	88
. 00 09000 CLINIC	HEALTH GENTER	94, 758		0	94, 7	-	90
. 00 09100 EMERGENCY		107, 578		0	107, 5		91
. 00 09200 OBSERVATION BEDS (NO	N-DISTINCT PART)			0			92
. 00 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CE	INTEDS	0		0		0	93
1.00 10100 HOME HEALTH AGENCY	INTERS	67,016	[	0	67, 0	16	101
SPECIAL PURPOSE COST CENTE	RS			-1			
6. 00 11600 HOSPI CE		7,352		0	7,3		116
8.00 SUBTOTALS (SUM OF LI NONREI MBURSABLE COST CENTE		1, 517, 529		0	1, 517, 5	29	118
0.00 19000 GIFT, FLOWER, COFFEE		3, 954		0	3, 9	54	190
2. 00 19200 PHYSI CI ANS' PRI VATE		0,701		Ő	0, 7	0	192
2.01 19201 RENSSELAER HEALTH CE	NTER	0		0		0	192
3. 00 19300 NONPALD WORKERS		177 000		0	177 0	0	193
4. 00 07950 ALTERNACARE 4. 01 07951 DME EQUI PMENT		177, 209		0	177, 2	0	194 194
4. 02 07952 KV HEALTH CENTER		41, 747		0	41, 7	47	194
4.0307957ST. JOE HEALTH CENTE	R	809		0	8	09	194
4. 04 07953 FOUNDATI ON		213		0		13	194
4.05 07954 MEALS ON WHEELS		3, 108		0	3, 1		194
4. 06 07955 WATER LAB 4. 07 07956 ADVERTI SI NG		10, 535 5, 218		0	10, 5 5, 2		194 194
0.00 Cross Foot Adjustmen	ts	0,210		0	5, 2	0	200
1.00 Negative Cost Center	S	0		0		0	201
2.00 TOTAL (sum lines 118	-201)	1, 760, 322		0	1, 760, 3	22	202

	Financial Systems LLOCATION - STATISTICAL BASIS	JASPER COUNTY			Peri od:	u of Form CMS- Worksheet B-1	
					From 01/01/2015 To 08/31/2015	Date/Time Pre 8/15/2016 3:5	pared:
	Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatio	ADMI NI STRATI VE & GENERAL (ACCUM. COST)		
		1.00	4.00	5A	5.00	7.00	<u> </u>
$\begin{array}{c} 1.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00 \end{array}$	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	106,008 0 11,170 1,866 1,617 1,914 1,958 1,844 403 0 1,008 1,365 93	10, 170, 241 1, 603, 897 162, 518 40, 729 252, 301 110, 623 104, 187 108, 595 12, 419 247, 145 200, 648 29, 920	-3, 586, 68	0         749, 567           0         100, 853           0         427, 419           0         223, 000	1, 914 1, 958 1, 844 403 0 1, 008 1, 365	8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00
30. 00 31. 00 41. 00 42. 00 43. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY	10, 206 756 0 0 0	812, 462 430, 257 C C		0 1, 272, 629 0 576, 899 0 0 0 0 0 0 0	10, 206 756 0 0	30.00 31.00 41.00 42.00
71.00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06000 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 RKSPIRATORY THERAPY 06600 KV HEALTH PT 06700 OCCUPATIONAL THERAPY 06600 SPEECH PATHOLOGY 06800 SPEECH PATHOLOGY 06800 SPEECH PATHOLOGY 06801 KV HEALTH ST 07100 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0UTPATIENT SERVICE COST CENTERS	11, 470 0 9, 624 0 0 2, 464 0 200 3, 238 2, 463 8, 276 1, 871 1, 913 604 1, 694 0 1, 137 149 0	364, 468 680, 639 680, 639 0 487, 334 0 580, 547 319, 787 355, 270 274, 426 82, 127 88, 636 72, 723 0 0 0 0 0 0 0 0 0 0 0 0 0		0         1, 151, 107           0         1, 670, 729           0         0           0         1, 670, 729           0         0           0         1, 240, 250           0         0           0         71, 043           0         71, 043           0         71, 043           0         71, 043           0         875, 115           0         589, 396           0         653, 201           395, 886         150, 996           0         127, 861           0         152, 790           0         27, 832           0         0		$ \begin{array}{c} 52.\ 00\\ 54.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 01\\ 63.\ 00\\ 65.\ 00\\ 66.\ 01\\ 67.\ 00\\ 66.\ 01\\ 67.\ 00\\ 67.\ 01\\ 68.\ 00\\ 71.\ 00\\ 71.\ 00\\ 72.\ 00\\ \end{array} $
88.00 88.03 89.00 90.00 91.00 92.00 93.00	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC IV 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE 0THER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0 2,650 0 4,487 4,464 0	120, 785 146, 540 0 435, 924 613, 849 0 831, 313		0         233, 179           0         303, 733           0         0           0         650, 668           0         1, 611, 738           0         0           0         0	2, 650 0 4, 487 4, 464 0	88. 03 89. 00 90. 00 91. 00 92. 00
116.00 118.00		249 94, 239	103, 684 9, 673, 753		0 304, 366 8 17, 197, 704		116. 00 118. 00
192.00 192.01 193.00 194.00 194.01 194.02 194.03 194.04 194.05 194.06		230 0 0 8, 362 0 2, 348 0 0 0 0 0 554 275	0 0 0 315, 318 0 96, 173 46, 940 0 0 26, 865 11, 192		0         3, 819           0         0           0         0           0         0           0         553, 645           0         0           0         174, 107           0         79, 088           0         20, 784           0         60, 865           0         60, 865           0         44, 579	0 0 8, 362 0 2, 348 0 0 0 0 554	190.00 192.00 192.01 193.00 194.00 194.01 194.02 194.03 194.04 194.05 194.06 194.07 200.00 201.00

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 151324		Period:	Worksheet B-1		
				From 01/01/2015 To 08/31/2015			
	CAPI TAL RELATED COSTS						
Cost Center Description	NEW BLDG & FIXT	EMPLOYEE BENEFI TS	Reconciliatio	n ADMI NI STRATI VE & GENERAL	PLANT		
	(SQUARE FEET)	DEPARTMENT (GROSS		(ACCUM. COST)	(SQUARE FEET)		
	1.00	<u>SALARI ES)</u> 4. 00	5A	5.00	7.00		
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 760, 322			3, 586, 688		202. 00	
203.00 Unit cost multiplier (Wkst. B, Part I)	16. 605558	0. 277824		0. 197782	9. 656864	203.00	
204.00 Cost to be allocated (per Wkst. B, Part II)		C		185, 484	38, 653	204. 00	
205.00 Unit cost multiplier (Wkst. B, Part		0. 000000		0. 010228	0. 415749	205. 00	

COST A	i Financial Systems ALLOCATION - STATISTICAL BASIS	JASPER COUNT			Period:	u of Form CMS-2 Worksheet B-1	
					From 01/01/2015 To 08/31/2015	Date/Time Pre	pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	CAFETERI A (MAN HOURS)	8/15/2016 3:5 NURSI NG ADMI NI STRATI ON (MAN HOURS)	
		8.00	9.00	10.00	11.00	13.00	
1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	48, 860 0 0 0 0 0 0 0 0 0 0 0	106, 855 470 270 0 1, 255 0 0	23, 69	9 0 242, 074 0 3, 214 0 0 0 7, 123 0 10, 949 0 1, 263	134, 298 0 0 0 0	1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00
30. 00 31. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	18, 716	-	9, 54	7 41, 891	41, 891 13, 191	30.00 31.00
41.00 42.00 43.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER – I RF 04300 NURSERY	0	0 0 0			0 0 0	41.00 42.00 43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	3, 867	0		0 14,779	14, 779	50.00
50.00 52.00 54.00 57.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	3, 867 0 3, 551 0	0 0 9, 675 0		0 14, 779 0 0 0 23, 808 0 0	14, 779 0 23, 808 0	52.00
58. 00 59. 00 60. 00	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 0 0	0 0 5, 815		0 0 0 0 0 20, 330	0 0 0	58.00 59.00 60.00
60. 01 63. 00 65. 00 66. 00 66. 01 67. 00 67. 01	06001 BLOOD LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06601 KV HEALTH PT 06700 OCCUPATIONAL THERAPY 06701 KV HEALTH OT	0 0 701 4, 183 0 0 0	0 2, 023 0		0 0 0 21, 540 0 11, 016 0 9, 454 0 0 0	0 0 0 0 0 0 0 0	60. 01 63. 00 65. 00 66. 00 66. 01 67. 00 67. 01
	06800 SPEECH PATHOLOGY 06801 KV HEALTH ST 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS 0UTPATI ENT SERVI CE COST CENTERS		653 0 0 0 0		0 3, 053 0 0 0 0 0 1, 259 0 0 0 0	0 0 1, 259 0 0	72.00
88.00 88.03 89.00 90.00 91.00 92.00 93.00	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC IV 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 0BSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE 0THER REIMBURSABLE COST CENTERS	0 0 2, 780 6, 123 0		31	0 0 0 0 4 15, 107 0 24, 263 0 0	0 0 15, 107 24, 263 0	88. 03 89. 00 90. 00 91. 00 92. 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	5, 340		0 0	0	101.00
116.00 118.00	11600 HOSPI CE	0 41, 942	0 87, 120	10, 95	0 0 4 222, 240	0 134, 298	116. 00 118. 00
192.00 192.01 193.00 194.00 194.01 194.02	19200 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRI VATE OFFI CES 19201 RENSSELAER HEALTH CENTER 19300 NONPAI D WORKERS 07950 ALTERNACARE 107951 DME EQUI PMENT 207952 KV HEALTH CENTER 307957 ST. JOE HEALTH CENTER	0 0 0 6, 918 0 0 0	0 0 0 18, 800 0 0 0	10, 68	0 0 0 0 0 0 6 18, 115 0 0 0 0 0 0 0 0	0 0 0 0 0 0	190.00 192.00 192.01 193.00 194.00 194.01 194.02 194.03
194.04 194.05 194.06 194.07 200.00 201.00	4 07953 FOUNDATION 5 07954 MEALS ON WHEELS 5 07955 WATER LAB 7 07956 ADVERTISING D Cross Foot Adjustments D Negative Cost Centers		0 0 935 0	2, 05	0 0 9 0 0 1, 142 0 577	0 0 0	194. 04 194. 05 194. 06 194. 07 200. 00 201. 00
	Cost to be allocated (per Wkst. B,	136, 415	530, 438	288, 34	6 308, 887	183, 958	

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS				Period: From 01/01/2015	Worksheet B-1		
				To 08/31/2015			
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG		
	LINEN SERVICE	(HOURS OF	(MEALS	(MAN	ADMI NI STRATI ON		
	(DOLLAR	SERVI CE)	SERVED)	HOURS)			
	VALUE)				(MAN		
					HOURS)		
	8.00	9.00	10.00	11.00	13.00		
203.00 Unit cost multiplier (Wkst. B, Part I)	2. 791957	4. 964092	12. 16701	1 1. 276002	1. 369775	203.00	
204.00 Cost to be allocated (per Wkst. B, Part II)	28, 555	36, 951	35, 77	2 33, 955	8, 814	204.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 584425	0. 345805	1. 50943	1 0. 140267	0. 065630	205.00	

	Financial Systems LUCATION - STATISTICAL BASIS	JASPER COUNT		CCN: 151324	In Lie Period:	u of Form CMS-2552-10 Worksheet B-1
0001 /12				0011. 101021	From 01/01/2015 To 08/31/2015	Date/Time Prepared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (100% ALLOCATI ON) 14. 00	PHARMACY (100% ALLOCATI ON) 15.00	MEDI CAL RECORDS & LI BRARY (TI ME SPENT) 16.00	SOCIAL SERVICE (TIME SPENT) 17.00	8/15/2016 3:56 pm
H H	GENERAL SERVICE COST CENTERS					
4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	100 0 0 0		0 0 98, 3 0	54 0 648	1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00
	03000 ADULTS & PEDIATRICS	0		0 28, 3		30.00
41.00 42.00 43.00	03100   NTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0 0 0		0 0 0 0	0 56 0 0 0 0 0 0 0 0	31. 00 41. 00 42. 00 43. 00
50.00 52.00 54.00 57.00	05000 OPERATI NG ROOM 05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	000000000000000000000000000000000000000		0 10, 3 0 0 20, 5 0	0 0	50.00 52.00 54.00 57.00 58.00
59. 00 60. 00 60. 01	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS.			0 0 2, 3 0	0 0 95 0 0 0	59.00 60.00 60.01 63.00
65. 00 66. 00 66. 01	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06601 KV HEALTH PT					65. 00 66. 00 66. 01
67. 01 68. 00 68. 01	06700 OCCUPATIONAL THERAPY 06701 KV HEALTH OT 06800 SPEECH PATHOLOGY 06801 KV HEALTH ST 07000 ELECTROENCEPHALOGRAPHY					67. 00 67. 01 68. 00 68. 01 70. 00
71.00 72.00 73.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 0UTPATIENT SERVICE COST CENTERS	100 0 0	10	0 0 0	0 0 0 0 0 0	71. 00 72. 00 73. 00
88.00	08800 RURAL HEALTH CLINIC	0		0	0 0	88.00
89.00 90.00 91.00	08801 RURAL HEALTH CLINIC IV 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY	0		0 0 22,89 0 13,89		88. 03 89. 00 90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04040 FAMILY PRACTICE	0		o	0 0	92.00 93.00
	OTHER REIMBURSABLE COST CENTERS	0			0 0	
	SPECIAL PURPOSE COST CENTERS	1		- <b>L</b>		
118.00	11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0 100	10	0 0 98, 3	0 0 54 648	116. 00 118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0			0 0 0 0	190. 00 192. 00
192.01	19201 RENSSELAER HEALTH CENTER 19300 NONPAID WORKERS	0		0	0 0	192. 01 193. 00
194.00	07950 ALTERNACARE	0		0	0 0	194.00
	07951 DME EQUIPMENT 07952 KV HEALTH CENTER	0		0	0 0 0 0	194. 01 194. 02
	07957 ST. JOE HEALTH CENTER	0		0	0 0	194. 03 194. 04
194.05	07953 FOUNDATION 07954 MEALS ON WHEELS	0		0	0 0	194. 05
194.07	07955 WATER LAB 07956 ADVERTI SI NG	0			0 0 0 0	194. 06 194. 07
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers					200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	27, 421	1, 820, 20	0 406, 70	51, 020	202.00

Health Fin	ancial Systems	JASPER COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLO	CATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2015	Worksheet B-1		
					o 08/31/2015	Date/Time Pre 8/15/2016 3:5		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE			
		SERVICES &	(100%	RECORDS &				
		SUPPLY	ALLOCATION)	LI BRARY	(TIME			
		(100%		(TIME	SPENT)			
		ALLOCATION)		SPENT)				
		14.00	15.00	16.00	17.00			
203.00	Unit cost multiplier (Wkst. B, Part I)	274. 210000	18, 202. 000000	4. 135155	78. 734568		203.00	
204.00	Cost to be allocated (per Wkst. B,	234	33, 919	28, 01 <sup>-</sup>	2, 174		204.00	
	Part II)							
205.00	Unit cost multiplier (Wkst. B, Part	2. 340000	339. 190000	0. 284798	3. 354938		205.00	

COMPUTATI ON	I OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151324	Period: From 01/01/2015 To 08/31/2015	Worksheet C Part I Date/Time Pre 8/15/2016 3:5	epared:
			Titl	e XVIII	Hospi tal	Cost	o piii
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	B RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	0 ADULTS & PEDIATRICS	2, 288, 619		2, 288, 6	19 0	0	30.00
31.00 0310	O INTENSIVE CARE UNIT	767, 150		767, 1	50 0	0	31.00
41.00 0410	O SUBPROVIDER - IRF	0			0 0	0	41.00
42.00 0420	O SUBPROVI DER	0			0 0	0	42.00
43.00 0430	0 NURSERY	0			0 0	0	43.00
ANCI I	LLARY SERVICE COST CENTERS						
50.00 0500	O OPERATING ROOM	1, 582, 234		1, 582, 2	34 0	0	50.00
52.00 0520	O DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
54.00 0540	0 RADI OLOGY-DI AGNOSTI C	2, 300, 010		2, 300, 0	10 0	0	54.00
57.00 0570	O CT SCAN	0		1	0 0	0	57.00
58.00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
59.00 0590	O CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60.00 0600	0 LABORATORY	1, 574, 055		1, 574, 0	55 0	0	60.00
60.01 0600	1 BLOOD LABORATORY	0			0 0	0	60.01
63.00 0630	O BLOOD STORING, PROCESSING & TRANS.	87, 025		87, 0	25 0	0	63.00
	RESPIRATORY THERAPY	1, 130, 973	0	1, 130, 9	73 0	0	65.00
66.00 0660	O PHYSI CAL THERAPY	768, 712	0			0	66.00
	1 KV HEALTH PT	862, 312				0	66.01
	O OCCUPATIONAL THERAPY	514, 358				0	67.00
	1 KV HEALTH OT	199, 334	0	199, 3		0	
	O SPEECH PATHOLOGY	166, 121	0			0	
	1 KV HEALTH ST	176, 511	0	176, 5		0	
	0 ELECTROENCEPHALOGRAPHY	0	-		0 0	0	
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	224, 741		224, 7	-	0	
	O I MPL. DEV. CHARGED TO PATIENT	34, 776		34, 7		0	
	O DRUGS CHARGED TO PATIENTS	1, 820, 200		1, 820, 2		0	
	ATIENT SERVICE COST CENTERS	1, 020, 200		1,020,2	<u> </u>		1 01 00
	O RURAL HEALTH CLINIC	279, 298		279, 2	98 0	0	88.00
	1 RURAL HEALTH CLINIC IV	389, 397		389, 3		0	
	O FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
	O CLINIC	968, 910		968, 9		0	
	0 EMERGENCY	2, 149, 391		2, 149, 3		0	
	O OBSERVATION BEDS (NON-DISTINCT PART)	651, 686		651, 6		0	
	O FAMILY PRACTICE	001,000			0 0	0	
	R REIMBURSABLE COST CENTERS				-, 0	0	1
	O HOME HEALTH AGENCY	1, 536, 687		1, 536, 6	87	0	101.00
	I AL PURPOSE COST CENTERS	.,,,,,	<u> </u>	.,	- <u> </u>	Ŭ	
116.001160		366, 969		366, 9	69	0	1116.00
200.00	Subtotal (see instructions)	20, 839, 469					200.00
201.00	Less Observation Beds	651, 686		651, 6			200.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151324	Peri od:	Worksheet C	
				From 01/01/2015 To 08/31/2015	Part I Date/Time Pre	
		T: +1	e XVIII	Hocpi tal	8/15/2016 3:5 Cost	6 pm
· · · · · · · · · · · · · · · · · · ·		Charges	e xviii	Hospi tal	COST	
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
	6.00	7.00	8.00	9.00	Rati o 10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	-
30. 00 03000 ADULTS & PEDIATRICS	1, 787, 495		1, 787, 49	25		30.00
31. 00 03100 I NTENSI VE CARE UNI T	349,650		349, 65			31.00
41. 00 04100 SUBPROVI DER – I RF	0		017,00	0		41.00
42. 00 04200 SUBPROVI DER	0			0		42.00
43. 00 04300 NURSERY	0			0		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	586, 558	2, 170, 342	2, 756, 90	0. 573918	0.00000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0.000000	0.00000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	418, 567	5, 019, 823	5, 438, 39		0. 000000	
57.00 05700 CT SCAN	0	C		0 0. 000000	0. 000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0.000000	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C	D	0 0.000000	0. 000000	
50. 00 06000 LABORATORY	907, 382	4, 673, 561	5, 580, 94		0.00000	
60. 01 06001 BLOOD LABORATORY	0	C		0 0.000000	0.00000	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	63, 632	94, 188			0.00000	
65. 00 06500 RESPI RATORY THERAPY	907, 429	1,020,453			0.00000	
66. 00 06600 PHYSI CAL THERAPY	114, 335	822, 980			0.00000	
66. 01 06601 KV HEALTH PT	0	740, 170			0.00000	
67. 00 06700 OCCUPATI ONAL THERAPY	83, 280	131, 792			0.00000	
67.01 06701 KV HEALTH OT 68.00 06800 SPEECH PATHOLOGY	10 7(0	106, 565			0.00000	
68. 00 06800 SPEECH PATHOLOGY 68. 01 06801 KV HEALTH ST	10, 760 0	60, 621 82, 886			0. 000000 0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	02, 000		0 0.00000	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	91, 758	460, 350	1		0. 000000	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	18, 324	57, 751			0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 489, 733	2, 825, 717			0.000000	
OUTPATIENT SERVICE COST CENTERS	1, 107, 700	2,020,717	1,010,10	0. 121707	0.00000	10.00
88. 00 08800 RURAL HEALTH CLINIC	0	180, 018	180, 01	18		88. 0
88.03 08801 RURAL HEALTH CLINIC IV	0	271, 591				88.0
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0		89.00
90. 00 09000 CLINIC	116, 657	1, 455, 572	1, 572, 22	0. 616265	0. 000000	90.00
91. 00 09100 EMERGENCY	12, 427	1, 851, 101			0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 559	981, 295			0.00000	92.00
93.00 04040 FAMILY PRACTICE	0	C		0 0.000000	0. 000000	93.00
OTHER REIMBURSABLE COST CENTERS						
101.0010100 HOME HEALTH AGENCY	0	871, 019	871, 01	19		101.00
SPECIAL PURPOSE COST CENTERS			1			
116. 00 11600 H0SPI CE	0	494, 986				116.00
200.00 Subtotal (see instructions)	6, 966, 546	24, 372, 781	31, 339, 32	27		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	6, 966, 546	24, 372, 781	31, 339, 32	27		202.00

Health Finan	cial Systems	JASPER COUNTY H	HOSPI TAL	In Lieu	u of Form CMS-	-2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provider CCN: 151324	Period:	Worksheet C	
				From 01/01/2015 To 08/31/2015	Part I Date/Time Pro	enared
				10 00/31/2013	8/15/2016 3:	
			Title XVIII	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	IENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS					30.00
	INTENSIVE CARE UNIT					31.00
	SUBPROVIDER - IRF					41.00
	SUBPROVI DER					42.00
	NURSERY					43.00
	LARY SERVICE COST CENTERS					_
	OPERATING ROOM	0. 000000				50.00
	DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
	RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
	CT SCAN	0. 000000				57.00
	MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
	CARDI AC CATHETERI ZATI ON	0. 000000				59.00
	LABORATORY	0. 000000				60.00
	BLOOD LABORATORY	0. 000000				60.01
	BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
	RESPI RATORY THERAPY	0. 000000				65.00
	PHYSI CAL THERAPY	0. 000000				66.00
	KV HEALTH PT	0. 000000				66. 01
	OCCUPATIONAL THERAPY	0. 000000				67.00
	KV HEALTH OT	0. 000000				67.01
	SPEECH PATHOLOGY	0. 000000				68.00
	KV HEALTH ST	0. 000000				68.01
	ELECTROENCEPHALOGRAPHY	0. 000000				70.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
	IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
	DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	TI ENT SERVICE COST CENTERS					
	RURAL HEALTH CLINIC					88.00
	RURAL HEALTH CLINIC IV					88.03
	FEDERALLY QUALIFIED HEALTH CENTER	0,000000				89.00
	EMERGENCY	0.000000				90.00 91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				91.00
	FAMILY PRACTICE	0.000000				92.00
	REIMBURSABLE COST CENTERS	0.000000				93.00
	HOME HEALTH AGENCY					101.00
	AL PURPOSE COST CENTERS					
116.0011600						116.00
200.00	Subtotal (see instructions)					200.00
200.00	Less Observation Beds					200.00
201.00	Total (see instructions)					201.00
202.00		I I				1-02.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151324	Period: From 01/01/2015 To 08/31/2015	Date/Time Pre	pared:
			le XIX	llaani tal	8/15/2016 3:5 Cost	<u>6 pm</u>
		111		Hospi tal Costs	COST	1
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs		Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 288, 619		2, 288, 6	19 0		
31.00 03100 INTENSIVE CARE UNIT	767, 150		767, 1	50 0	767, 150	31.00
11. 00 04100 SUBPROVIDER - IRF	0			0 0	0	41.00
12. 00 04200 SUBPROVI DER	0			0 0	0	42.00
43. 00 04300 NURSERY	0			0 0	0	43.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 582, 234		1, 582, 2	34 0	1, 582, 234	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 300, 010		2, 300, 0	10 0	2, 300, 010	54.00
57.00 05700 CT SCAN	0			0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	
50. 00 06000 LABORATORY	1, 574, 055		1, 574, 0	55 0	1, 574, 055	60.00
50. 01 06001 BLOOD LABORATORY	0			0 0	0	
53.00 06300 BLOOD STORING, PROCESSING & TRANS.	87, 025		87, 0		87, 025	
55. 00 06500 RESPI RATORY THERAPY	1, 130, 973				1, 130, 973	
56. 00 06600 PHYSI CAL THERAPY	768, 712				768, 712	
56.01 06601 KV HEALTH PT	862, 312				862, 312	
57.00 06700 OCCUPATI ONAL THERAPY	514, 358					
57.01 06701 KV HEALTH OT	199, 334	0	199, 3	34 0	199, 334	67.0
58.00 06800 SPEECH PATHOLOGY	166, 121	0	166, 1	21 0	166, 121	68.00
58.01 06801 KV HEALTH ST	176, 511	0	176, 5	11 0	176, 511	68.0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	224, 741		224, 7			
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	34, 776		34, 7			
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 820, 200		1, 820, 2	00 00	1, 820, 200	73.00
OUTPATIENT SERVICE COST CENTERS	- i	1	1			
38.00 08800 RURAL HEALTH CLINIC	279, 298		279, 2			
38.03 08801 RURAL HEALTH CLINIC IV	389, 397		389, 3	97 0	389, 397	
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0		
90. 00 09000 CLINIC	968, 910		968, 9		968, 910	
91.00 09100 EMERGENCY	2, 149, 391		2, 149, 3		_, ,	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	651, 686		651, 6		651, 686	
P3. 00 04040 FAMILY PRACTICE	0			0 0	0	93.00
OTHER REIMBURSABLE COST CENTERS				o =		
101.00 10100 HOME HEALTH AGENCY	1, 536, 687		1, 536, 6	87	1, 536, 687	1101.00
SPECIAL PURPOSE COST CENTERS	0// 5:-			(0)	<u> </u>	1
116. 00 11600 HOSPI CE	366, 969		366, 9		366, 969	
200.00 Subtotal (see instructions)	20, 839, 469					
201.00 Less Observation Beds	651, 686		651, 6		651, 686	
202.00 Total (see instructions)	20, 187, 783	0	20, 187, 7	83 0	20, 187, 783	202.00

COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151324	Peri od:	Worksheet C	
					From 01/01/2015 To 08/31/2015	Part I Date/Time Pre 8/15/2016 3:5	
			Ti t	le XIX	Hospi tal	Cost	o piii
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	ATLENT ROUTINE SERVICE COST CENTERS						
	DO ADULTS & PEDIATRICS	1, 787, 495		1, 787, 49			30.00
	DO INTENSIVE CARE UNIT	349, 650		349, 65			31.00
	DO SUBPROVIDER - IRF	0			0		41.00
	DO SUBPROVI DER	0			0		42.00
	DO NURSERY	0			0		43.00
	LLARY SERVICE COST CENTERS	504 550	0.470.040	0.75/.0/			1
	DO OPERATING ROOM	586, 558	2, 170, 342	2, 756, 90		0.00000	
	DO DELIVERY ROOM & LABOR ROOM	0	5 010 000	F 400 00	0 0.00000	0.00000	
	DO RADI OLOGY-DI AGNOSTI C	418, 567	5, 019, 823			0. 000000	
	DO CT SCAN	0	0		0 0.000000 0 0.000000	0.000000	
	DO MAGNETIC RESONANCE IMAGING (MRI) DO CARDIAC CATHETERIZATION	0	0		0 0.000000	0. 000000	
	DO LABORATORY	907, 382	4, 673, 561	5, 580, 94		0. 000000	
	DI BLOOD LABORATORY	907, 382	4, 073, 301		0 0. 000000	0. 000000	
	DO BLOOD STORING, PROCESSING & TRANS.	63, 632	94, 188			0. 000000	
	DO RESPIRATORY THERAPY	907, 429	1, 020, 453			0. 000000	
	DO PHYSI CAL THERAPY	114, 335	822, 980			0. 000000	
	D1 KV HEALTH PT	0	740, 170			0. 000000	
	DO OCCUPATIONAL THERAPY	83, 280	131, 792			0. 000000	
	D1 KV HEALTH OT	0	106, 565			0.000000	
58.00 0680	DO SPEECH PATHOLOGY	10, 760	60, 621			0.000000	68.0
58.01 0680	D1 KV HEALTH ST	0	82, 886	82, 88	2. 129563	0.000000	68.0
70.00 0700	DO ELECTROENCEPHALOGRAPHY	0	C		0 0.000000	0.000000	70.0
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	91, 758	460, 350	552, 10		0.00000	
	DO IMPL. DEV. CHARGED TO PATIENT	18, 324	57, 751			0.00000	
	DO DRUGS CHARGED TO PATIENTS	1, 489, 733	2, 825, 717	4, 315, 45	0. 421787	0.00000	73.0
	PATIENT SERVICE COST CENTERS	1 1		1			
	DO RURAL HEALTH CLINIC	0	180, 018			0.00000	
	DI RURAL HEALTH CLINIC IV	0	271, 591			0.00000	
	DO FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00000	0.00000	
		116, 657	1, 455, 572			0.00000	
		12, 427	1, 851, 101			0.00000	
	DO OBSERVATION BEDS (NON-DISTINCT PART)	8, 559	981, 295			0.00000	
	40 FAMILY PRACTICE ER REIMBURSABLE COST CENTERS	0	0	1	0 0.000000	0. 000000	93.00
	DO HOME HEALTH AGENCY	0	871,019	871, 01	0		101.00
	CIAL PURPOSE COST CENTERS		671,019	0/1,0	7		
116.001160		0	494, 986	494, 98	36		1116. 0
200.00	Subtotal (see instructions)	6, 966, 546	24, 372, 781				200.00
201.00	Less Observation Beds	2, 700, 040	2., 3, 2, 701	0.,007,02			201.00
	Total (see instructions)	6, 966, 546	24, 372, 781	31, 339, 32	1		202.00

	inancial Systems	JASPER COUNTY H			u of Form CMS-	-2552-10
COMPUTAT	TION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151324	Period: From 01/01/2015 To 08/31/2015	Worksheet C Part I Date/Time Pre 8/15/2016 3:5	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient Ratio				
		11.00				
	NPATI ENT ROUTI NE SERVI CE COST CENTERS 3000 ADULTS & PEDI ATRI CS					30.00
	3100 I NTENSI VE CARE UNI T					31.00
	4100 SUBPROVIDER - IRF					41.00
	4200 SUBPROVIDER - TRF					41.00
	4300 NURSERY					43.00
	NCI LLARY SERVI CE COST CENTERS 5000 OPERATI NG ROOM	0.000000				
		0.000000				50.00
	5200 DELIVERY ROOM & LABOR ROOM	0.000000				52.00
	5400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
	5700 CT SCAN	0. 000000				57.00
	5800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000				58.00
	5900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
	6000 LABORATORY	0. 000000				60.0
	6001 BLOOD LABORATORY	0. 000000				60.0
	6300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
	6500 RESPI RATORY THERAPY	0. 000000				65.00
	6600 PHYSI CAL THERAPY	0. 000000				66.00
	6601 KV HEALTH PT	0. 000000				66. O
	6700 OCCUPATIONAL THERAPY	0. 000000				67.00
	6701 KV HEALTH OT	0. 000000				67.0
	6800 SPEECH PATHOLOGY	0. 000000				68.0
	6801 KV HEALTH ST	0. 000000				68.0
	7000 ELECTROENCEPHALOGRAPHY	0. 000000				70.0
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.0
	7200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.0
	7300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	UTPATIENT SERVICE COST CENTERS					_
	8800 RURAL HEALTH CLINIC	0. 000000				88.00
	8801 RURAL HEALTH CLINIC IV	0. 000000				88. 03
	8900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89.00
	9000 CLINIC	0. 000000				90.00
	9100 EMERGENCY	0. 000000				91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
	4040 FAMILY PRACTICE	0. 000000				93.00
	THER REIMBURSABLE COST CENTERS					
	0100 HOME HEALTH AGENCY					101.00
	PECIAL PURPOSE COST CENTERS					
116.001	1600 HOSPI CE					116. 00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 151324	Peri od:	Worksheet D	
				From 01/01/2015 To 08/31/2015		narod
				10 00/31/2013	8/15/2016 3:5	
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	015.0(0	0.75/.000	0.0700			
50.00 05000 OPERATING ROOM	215, 260	2, 756, 900			31, 474	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	U 5 400 000	0.0000		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	197, 076	5, 438, 390			10, 465	
57.00 05700 CT SCAN	0	0	0.0000		0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0.0000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	(0.170		0.0000		0	59.00
60. 00 06000 LABORATORY	60, 170	5, 580, 943				60.00 60.01
60. 01 06001 BLOOD LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	4 121	157.000	0.0000		0 1, 182	63.00
65. 00 06500 RESPIRATORY THERAPY	4, 131					
66. 00 06600 PHYSICAL THERAPY	69, 034 52, 862				25, 393 3, 208	
66. 01 06600 PHYSICAL THERAPY 66. 01 06601 KV HEALTH PT					3, 208	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	147, 550 37, 922					
67. 01 06701 KV HEALTH OT	34, 105				0,039	67.00
68. 00 06800 SPEECH PATHOLOGY	12, 243					
68. 01 06801 KV HEALTH ST	30, 202				1, 390	68.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	30, 202		0. 0000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 411	, o			-	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 821					
73. 00 07300 DRUGS CHARGED TO PATIENTS	33, 919					
OUTPATIENT SERVICE COST CENTERS	55,717	4, 313, 430	0.0070	000,000	5,114	/ 5. 00
88.00 08800 RURAL HEALTH CLINIC	2, 385	180, 018	0.0132	19 0	0	88.00
88.03 08801 RURAL HEALTH CLINIC IV	48, 214				0	88.03
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	10, 214	2,1,3,1	0.0000		0	
90. 00 09000 CLINIC	94, 758	1, 572, 229			-	
91. 00 09100 EMERGENCY	107, 578				97	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	70, 128				0	1
93. 00 04040 FAMILY PRACTICE	0				0	93.00
200.00 Total (lines 50-199)	1, 241, 769	27, 836, 177		2, 935, 440	97, 746	
		•				

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CN: 151324         Period: From 0701/2015 To 08/31/2016         Worksheet D Part IV Date/Time Prepared: Cost           Title XVIII         Hospital         Cost         Title XVIII         Hospital         Cost         Cost           Morksheet D Provider CN: 151324         Period: From 0701/2015         Title XVIII         Hospital         Cost           Title XVIII         Hospital         Cost         Cost         Cost         Total Cost	Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-	2552-10
Cost Center Description         Non Physic Lan Nursing School         All ied Health         All other Medical Education Cost         Total Cost (sum of col 1 4)           ANCI LLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 OPERATING ROOM         0		RVICE OTHER PASS			From 01/01/2015 To 08/31/2015	Part IV Date/Time Pre 8/15/2016 3:5	
Ancite tist Cost         Medical Education Cost         (sum of col 1 through col . 4)           ANCILLARY SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           50.00         05000 (PERATING ROM 0 0000 (CARDANOSTIC 00 0							
ANCLILLARY SERVICE COST CENTERS         0 <t< td=""><td>Cost Center Description</td><td>Anesthetist Cost</td><td></td><td></td><td>Medical Education Cost</td><td>(sum of col 1 through col. 4)</td><td></td></t<>	Cost Center Description	Anesthetist Cost			Medical Education Cost	(sum of col 1 through col. 4)	
50.00       05000       0PERATING ROOM       0 <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td>4.00</td> <td>5.00</td> <td></td>		1.00	2.00	3.00	4.00	5.00	
52.00         05200         DELIVERY FROM & LABOR ROOM         0         0         0         0         0         0         0         0         52.00           54.00         05400         RADIOLOGY-DI AGNOSTI C         0	ANCI LLARY SERVICE COST CENTERS						
54.00       05400       RADI OLOGY-DI AGNOSTI C       0	50.00 05000 OPERATING ROOM	0	C		0 0	0	
57.00       05700       CT SCAN       0       0       0       0       57.00         58.00       05800       MAGNETI C RESONANCE I MAGI NG (MRI )       0       0       0       0       58.00         59.00       05900       CARDIAC CATHETERIZATION       0		0	C		0 0	0	
58.00       05800       MAGNETIC RESONANCE I MAGING (MRI)       0 </td <td>54. 00 05400 RADI OLOGY-DI AGNOSTI C</td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td>0</td> <td>54.00</td>	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
59.00       05900       CARDIAC CATHETERIZATION       0		0	C		0 0	0	57.00
60.00       LABORATORY       0       0       0       0       60.00         60.01       06001       BLOOD LABORATORY       0		0	C		0 0	0	
60.01       BLOOD LABORATORY       0		0	C		0 0	0	59.00
63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0       0       0       0       63.00         65.00       06500       RESPIRATORY THERAPY       0       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         66.01       06600       CQUPATIONAL THERAPY       0       0       0       0       66.00         67.00       06700       OCUPATIONAL THERAPY       0       0       0       0       67.00         67.01       06701       KV HEALTH OT       0       0       0       0       67.00         68.00       0800       SPEECH PATHOLOGY       0       0       0       0       68.01         68.01       06801       KV HEALTH ST       0       0       0       0       68.01         70.00       O7000       ELECTROENCEPHALOGRAPHY       0       0       0       0       70.00         71.00       O7100       MEUS CHARGED TO PATI ENTS       0       0       0       71.00       72.00       73.00         72.00       O7300       RUGS CHARGED TO PATI ENTS       0       0       0       0<		0	C		0 0	0	60.00
65.00       06500       RESPI RATORY THERAPY       0 <td< td=""><td></td><td>0</td><td>C</td><td></td><td>0 0</td><td>0</td><td></td></td<>		0	C		0 0	0	
66.00       06600       PHYSI CAL THERAPY       0<	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0	0	63.00
66.01       06601       KV HEALTH PT       0       0       0       0       0       0       67.00         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       0       67.00         67.01       06701       KV HEALTH OT       0       0       0       0       67.01         68.01       06800       SPEECH PATHOLOGY       0       0       0       68.00         68.01       06801       KV HEALTH ST       0       0       0       0       68.01         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       0       71.00         72.00       07200 I MPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       72.00         73.00       DT300 DRUGS CHARGED TO PATI ENTS       0       0       0       0       72.00         73.00       DRUBS CHARGED TO PATI ENTS       0       0       0       0       0       88.00         88.00       08800       RURAL HEALTH CLINIC       V       0       0       0	65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
67.00       06700       OCCUPATIONAL THERAPY       0       0       0       0       67.00         67.01       06701       KV HEALTH OT       0       0       0       0       0       67.01         68.00       06800       SPECH PATHOLOGY       0       0       0       0       0       0       68.00         68.01       06800       KV HEALTH ST       0       0       0       0       0       68.01         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       72.00         73.00       07300       RURAL HEALTH CLINIC       0       0       0       0       0       73.00         OUTPATI ENT SERVICE COST CENTERS         88.03       08301       RURAL HEALTH CLINIC IV       0       0       0       0       89.00         89.00       08900       FEDERALLY QUALI FIED HEALTH CENTER       0       0       0       0       0 <td></td> <td>0</td> <td>C</td> <td></td> <td>0 0</td> <td>0</td> <td></td>		0	C		0 0	0	
67.01       06701       KV HEALTH OT       0	66. 01 06601 KV HEALTH PT	0	C		0 0	0	66. 01
68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0       68.00         68.01       06801       KV HEALTH ST       0       0       0       0       0       0       68.01         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       73.00         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0       0       73.00         88.00       08801       RURAL HEALTH CLINIC IV       0       0       0       0       88.03         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       0       89.00         90.00       09000       CLINIC       0       0       0       0       0       0       90.00         91.00       09		0	C		0 0	0	67.00
68.01       06801       KV HEALTH ST       0		0	C	)	0 0	0	
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0         0         0         70.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0         0         0         0         0         0         71.00           72.00         07200         IMPL.         DEV. CHARGED TO PATIENT         0         0         0         0         0         72.00           73.00         DRUGS CHARGED TO PATIENTS         0         0         0         0         0         0         73.00           OUTPATIENT SERVICE COST CENTERS         0         0         0         0         0         0         0         88.00           88.00         08801         RURAL HEALTH CLINIC IV         0         0         0         0         88.00           88.03         08801         RURAL HEALTH CLINIC IV         0         0         0         89.00         89.00         89.00         89.00         89.00         89.00         90.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	68.00 06800 SPEECH PATHOLOGY	0	C	)	0 0	0	68.00
71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         0         0         0         0         0         71.00         72.00         07200         IMPL. DEV. CHARGED TO PATIENT         0         0         0         0         0         72.00         73.00         07300         DRUGS CHARGED TO PATIENTS         0         0         0         0         0         0         73.00           OUTPATIENT SERVICE COST CENTERS           OUTPATIENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC IV         0         0         0         0         88.00         89.00         90.00         90.00         90.00         90.00         90.00         90.	68. 01 06801 KV HEALTH ST	0	C	)	0 0	0	
72.00         07200         IMPL.         DEV.         CHARGED TO PATIENT         0         0         0         0         0         72.00         73.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0         0         0         0         0         0         73.00           0UTPATIENT SERVICE COST CENTERS         0         0         0         0         0         0         0         88.00           88.00         08800         RURAL HEALTH CLINIC         0         0         0         0         0         88.00           88.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0         88.03           99.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0         89.00           90.00         09000         CLINIC         0         0         0         0         90.00		0	C	)	0 0	0	70.00
73.00         07300         DRUGS CHARGED TO PATIENTS         0		0	C	)	0 0	0	71.00
OUTPATI ENT SERVICE COST CENTERS           88.00         08800         RURAL HEALTH CLINIC         0         0         0         0         88.00           88.03         08801         RURAL HEALTH CLINIC         V         0         0         0         0         88.03           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0         89.00           90.00         09000         CLINIC         0         0         0         0         90.00           91.00         09100         EMERGENCY         0         0         0         0         91.00         92.00         08580 (NON-DI STINCT PART)         0         0         0         92.00           93.00         04040         FAMILY PRACTICE         0         0         0         0         93.00		0	C	)	0 0	0	
88.00       08800       RURAL HEALTH CLINIC       0       0       0       0       0       88.00         88.03       08801       RURAL HEALTH CLINIC IV       0       0       0       0       88.03         89.00       08900       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       0       89.00         90.00       09000       CLINIC       0       0       0       0       90.00         91.00       09100       EMERGENCY       0       0       0       0       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0       0       0       0       92.00         93.00       04040       FAMILY PRACTICE       0       0       0       0       93.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	)	0 0	0	73.00
88.03         08801         RURAL HEALTH CLINIC IV         0         0         0         0         88.03           89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0         89.00           90.00         09000         CLINIC         0         0         0         0         0         90.00           91.00         09100         EMERGENCY         0         0         0         0         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0         0         0         0         92.00           93.00         04040         FAMILY PRACTICE         0         0         0         0         93.00	OUTPATIENT SERVICE COST CENTERS						
89.00         08900         FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0         89.00           90.00         09000         CLINIC         0         0         0         0         90.00           91.00         09100         EMERGENCY         0         0         0         0         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0         0         0         0         92.00           93.00         04040         FAMILY PRACTICE         0         0         0         0         93.00	88.00 08800 RURAL HEALTH CLINIC	0	C	)	0 0	0	88.00
90.00         09000         CLINIC         0         0         0         0         90.00           91.00         09100         EMERGENCY         0         0         0         0         0         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0         0         0         0         0         92.00           93.00         04040         FAMILY PRACTICE         0         0         0         0         0         93.00	88.03 08801 RURAL HEALTH CLINIC IV	0	C	)	0 0	0	88.03
91.00         09100         EMERGENCY         0         0         0         91.00         91.00         91.00         91.00         91.00         91.00         92.00         9200         OBSERVATION BEDS (NON-DISTINCT PART)         0         0         0         0         0         92.00         93.00         04040         FAMILY PRACTICE         0         0         0         0         0         0         93.00		0	C		0 0	0	89.00
92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART)         0         0         0         0         92.00           93.00         04040         FAMILY PRACTICE         0         0         0         0         0         93.00		0	C		0 0	0	
93. 00 04040 FAMILY PRACTICE 0 0 0 0 93. 00		0	C		0 0	0	
	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0 0	0	92.00
200.00           Total (lines 50-199)         0<	93. 00 04040 FAMILY PRACTICE	0	C		0 0	0	93.00
	200.00  Total (lines 50-199)	0	C		0 0	0	200. 00

Health Financial Systems	JASPER COUNT			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der	CCN: 151324	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2015 To 08/31/2015	Part IV Date/Time Pre	narodi
				10 06/31/2015	8/15/2016 3:5	
		Ti tl	e XVIII	Hospi tal	Cost	<u> </u>
Cost Center Description	Total	Total Charges			I npati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	-	
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS		1	1			
50. 00 05000 OPERATING ROOM	0	2,,00,,00			403, 101	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	-	0.0000		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	5, 438, 390			288, 776	•
57.00 05700 CT SCAN	0	C	0.0000		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	0.00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0.0000		0	
60. 00 06000 LABORATORY	0	5, 580, 943			587, 839	
60. 01 06001 BLOOD LABORATORY	0	C	0.0000		0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0				45, 171	63.00
65. 00 06500 RESPI RATORY THERAPY	0	1, , 2, , 002			709, 156	
66. 00 06600 PHYSI CAL THERAPY	0	937, 315			56, 880	
66. 01 06601 KV HEALTH PT	0	740, 170			0	
67.00 06700 OCCUPATI ONAL THERAPY	0	210/0/2			31, 980	
67.01 06701 KV HEALTH OT	0	106, 565			0	
68.00 06800 SPEECH PATHOLOGY	0	71, 381			8, 140	
68. 01 06801 KV HEALTH ST	0	82, 886			0	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C			0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	552, 108			64, 995	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0				14, 124	•
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	4, 315, 450	0.0000	0. 000000	650, 650	73.00
OUTPATIENT SERVICE COST CENTERS	-				-	
88.00 08800 RURAL HEALTH CLINIC	0					
88.03 08801 RURAL HEALTH CLINIC IV	0	,				
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.00000			
90. 00 09000 CLINIC	0	1,0,2,22,			72, 943	
91.00 09100 EMERGENCY	0	1,000,020			1, 685	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					
93. 00 04040 FAMILY PRACTICE	0			0. 000000		
200.00   Total (lines 50-199)	0	27, 836, 177	I		2, 935, 440	1200.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	JASPER COUNTY		CCN: 151324	Period:	eu of Form CMS- Worksheet D	2002-10
THROUGH COSTS			00111 101021	From 01/01/2015	Part IV	
				To 08/31/2015		
					8/15/2016 3:5	56 pm
			le XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program	6		
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)	12.00	x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS				0		
	0	(		0		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	(		0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	(		0		54.00
57.00 05700 CT SCAN	0	(	J	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	(	0	0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	(	0	0		59.00
60. 00 06000 LABORATORY	0	(	0	0		60.00
60. 01 06001 BLOOD LABORATORY	0	(	5	0		60.01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	(	5	0		63.00
65. 00 06500 RESPI RATORY THERAPY	0	(	0	0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	(	D	0		66.00
66. 01 06601 KV HEALTH PT	0	(	C	0		66. 01
67.00 06700 OCCUPATI ONAL THERAPY	0	(		0		67.00
67.01 06701 KV HEALTH OT	0	(	C	0		67.01
68.00 06800 SPEECH PATHOLOGY	0	(	C	0		68.00
58.01 06801 KV HEALTH ST	0	(	C	0		68.01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	(	C	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(	C	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	(	C	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	(	D	0		73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	(	C	0		88.00
88.03 08801 RURAL HEALTH CLINIC IV	0	(	C	0		88.03
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(	C	0		89.00
90. 00 09000 CLINIC	0	(	C	0		90.00
91. 00 09100 EMERGENCY	0	(	C	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(	C	0		92.00
93. 00 04040 FAMILY PRACTICE	0	(	C	0		93.00
200.00 Total (lines 50-199)	0	(	b	0		200.00

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151324	Period: From 01/01/2015	Worksheet D Part V	
				To 08/31/2015	Date/Time Pre 8/15/2016 3:5	
		Ti tl	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS		-			-	
50.00 05000 OPERATI NG ROOM	0. 573918				0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 422921	0	1, 727, 16	67 0	0	
57.00 05700 CT SCAN	0. 000000			0 0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	C		0 0	0	
60. 00 06000 LABORATORY	0. 282041	C	2, 157, 23		0	
60. 01 06001 BLOOD LABORATORY	0. 000000			0 0	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 551419		59, 94		0	
65. 00 06500 RESPI RATORY THERAPY	0. 586640		487, 97		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 820121	C	200, 11		0	
66. 01 06601 KV HEALTH PT	1. 165019		172, 83		0	
67.00 06700 OCCUPATI ONAL THERAPY	2. 391562		22, 79		0	
67.01 06701 KV HEALTH OT	1. 870539		12, 43		0	
68.00 06800 SPEECH PATHOLOGY	2. 327244		0,00		0	
68.01 06801 KV HEALTH ST	2. 129563		4, 03		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 407060		100/10		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 457128				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 421787	0	1, 246, 32	21 0	0	73.00
OUTPATIENT SERVICE COST CENTERS					-	
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	
88.03 08801 RURAL HEALTH CLINIC IV	0. 000000				0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
90. 00 09000 CLINIC	0. 616265				0	
91. 00 09100 EMERGENCY	1. 153399		525, 02		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 658366		457, 16	5 0	0	
93.00 04040 FAMILY PRACTICE	0. 000000	0		0 0	0	
200.00 Subtotal (see instructions)		0	8, 884, 53		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)		C	8, 884, 53	35 0	0	202.00

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	O VACCINE COST		CCN: 151324	Period: From 01/01/2015 To 08/31/2015	Worksheet D Part V Date/Time Pr 8/15/2016 3:	epared: 56 pm
		Ti tl	e XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	504, 404	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	730, 455	0				54.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	608, 430	l o				60.00
60. 01 06001 BLOOD LABORATORY	0	c c				60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	33, 056	l a				63.00
65. 00 06500 RESPI RATORY THERAPY	286, 263					65.00
66.00 06600 PHYSI CAL THERAPY	195, 576					66.00
66. 01 06601 KV HEALTH PT	201, 361					66.01
67.00 06700 OCCUPATI ONAL THERAPY	54, 525					67.00
67. 01 06701 KV HEALTH OT	23, 262					67.01
68. 00 06800 SPEECH PATHOLOGY	20, 685					68.00
68. 01 06801 KV HEALTH ST	8, 597					68.01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0,077		1			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	61, 237	-	1			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	14, 595					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	525, 682					73.00
OUTPATIENT SERVICE COST CENTERS	525,002		1			_ / 0.00
88. 00 08800 RURAL HEALTH CLINIC	0	C				88.00
88. 03 08801 RURAL HEALTH CLINIC IV	0	-	1			88.03
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0					89.00
90. 00 09000 CLINIC	433, 223	-				90.00
90. 00 109000 CET NTC 91. 00 09100 EMERGENCY	433, 223					90.00
						91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	300, 982					
93. 00 04040 FAMILY PRACTICE	1 (07 000	-	1			93.00
200.00 Subtotal (see instructions)	4, 607, 900					200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	4 (07 000					000 00
202.00  Net Charges (line 200 +/- line 201)	4, 607, 900	0	1			202.00

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period:	Worksheet D	
		0		From 01/01/2015		
		Component	t CCN: 15Z324	To 08/31/2015	Date/Time Pre 8/15/2016 3:5	pared: 6 nm
		Ti †I	e XVIII S	Swing Beds - SNF		
			Charges	Juring Bedd Sill	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(	
	Part I, col. 9	· · ·	Subject To	Subject To		
			Ded. & Coi ns.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 573918	C	)	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 422921	c c		o o	0	54.00
57.00 05700 CT SCAN	0. 000000	c		o o	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	c		o o	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000			0 0	0	59.00
60. 00 06000 LABORATORY	0. 282041			0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			0 0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 551419			0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 586640			0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 820121			0 0	0	66.00
66. 01 06601 KV HEALTH PT	1. 165019			0 0	0	66.01
67.00 06700 OCCUPATIONAL THERAPY	2. 391562			0 0	0	67.00
67. 01 06701 KV HEALTH OT	1. 870539			0 0	0	67.01
68. 00 06800 SPEECH PATHOLOGY	2. 327244			0 0	0	68.00
68. 01 06801 KV HEALTH ST	2. 129563			0 0	0	68.01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 407060			0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 457128			0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 421787			0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	01121707			<u> </u>		/0/00
88. 00 08800 RURAL HEALTH CLINIC	0.00000				0	88.00
88. 03 08801 RURAL HEALTH CLINIC IV	0. 000000				0	88.03
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
90. 00 09000 CLINIC	0. 616265			0 0	0	90.00
91. 00 09100 EMERGENCY	1. 153399			0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 658366			0 0	0	92.00
93. 00 04040 FAMILY PRACTICE	0. 000000				0	
200.00 Subtotal (see instructions)	0.00000				-	200.00
201.00 Less PBP Clinic Lab. Services-Program					0	200.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		l o		o o	0	202.00
	I.		Т	-1 0	, v	

Health Finar	ncial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS	-2552-10
APPORTI ONMEI	NT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST	Component	CCN: 151324 : CCN: 15Z324		8/15/2016 3:	epared: 56 pm
			Ti tl	e XVIII	Swing Beds - SNF	Cost	_
		Cos	ts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
ANCI L	LARY SERVICE COST CENTERS			_			
50.00 05000	OPERATING ROOM	0	0				50.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0				52.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	0	0				54.00
57.00 05700	CT SCAN	0	0				57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
	CARDI AC CATHETERI ZATI ON	0	0				59.00
	LABORATORY	0	0				60.00
	BLOOD LABORATORY	0	0				60.0
	BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
	RESPI RATORY THERAPY	0	0				65.00
	PHYSI CAL THERAPY	0	0				66.00
	KV HEALTH PT	0	0				66.0
	OCCUPATIONAL THERAPY	0	0				67.00
	KV HEALTH OT	0	0				67.0
	SPEECH PATHOLOGY	0	0				68.00
	KV HEALTH ST	0	0				68.0
	ELECTROENCEPHALOGRAPHY	0	0				
		0	0				70.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
	DRUGS CHARGED TO PATIENTS	0	0				73.00
	TI ENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC	0	0				88.00
	RURAL HEALTH CLINIC IV	0	0				88.03
	FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
	CLINIC	0	0				90.00
	EMERGENCY	0	0				91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	FAMILY PRACTICE	0	0				93.00
200. 00	Subtotal (see instructions)	0	0				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						1
202.00	Net Charges (line 200 +/- line 201)	0	0				202.00

	Financial Systems JASPER COUNTY H ATION OF INPATIENT OPERATING COST	Provi der CCN: 151324	Period: From 01/01/2015 To 08/31/2015		pare
		Title XVIII	Hospi tal	8/15/2016 3:50 Cost	6 рп
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
. 00	Inpatient days (including private room days and swing-bed days			3, 598	1.
. 00 . 00	Inpatient days (including private room days, excluding swing-b Private room days (excluding swing-bed and observation bed day		ivate room dave	3, 029 0	2.
. 00	do not complete this line.	(3). The you have only pr	i vate i ooni days,	0	3.
00	Semi-private room days (excluding swing-bed and observation be			2, 025	4
00	Total swing-bed SNF type inpatient days (including private roc reporting period	om days) through Decembe	r 31 of the cost	479	5.
00	Total swing-bed SNF type inpatient days (including private roc	om davs) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	90	7
00	reporting period Total swing-bed NF type inpatient days (including private room	u days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line)			J. J	
00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	1, 435	9
0. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	ly (including private r	oom days)	479	10
. 00	through December 31 of the cost reporting period (see instruct		com days)	-,,,	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XIX		e room dave)	0	12
. 00	through December 31 of the cost reporting period	Config (The during privat	e room days)	0	12
8.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13
00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)	an (excluding swing-bed	uays)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost		17
3. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18
	reporting period				
0. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	129. 14	19
). 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing pariod (line	2, 288, 619 0	
2.00	5 x line 17)	er si or the cost report	rng period (rine	0	22
3.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23
_	x line 18)			11 (00	
00	Swing-bed cost applicable to NF type services through December $7 \times 1$ (ine 19)	31 of the cost reporti	ng period (iine	11, 623	24
1.00			period (line 8	0	25
4.00 5.00	Swing-bed cost applicable to NF type services after December 3	I of the cost reporting	period (inic o		20
5. 00	x line 20)	and the cost reporting		222 527	
5. 00 5. 00	x line 20) Total swing-bed cost (see instructions)			322, 537 1 966 082	26
5. 00 5. 00	x line 20)			322, 537 1, 966, 082	26
00 00 00 00 00 00	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	(line 21 minus line 26)		1, 966, 082 0	26 27 28
. 00 . 00 . 00 . 00	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	(line 21 minus line 26)		1, 966, 082 0 0	26 27 28 29
5.00 5.00 7.00 8.00 9.00 9.00	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	(line 21 minus line 26) I and observation bed ch		1, 966, 082 0 0 0	26 27 28 29 30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ( <u>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</u> General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + Average private room per diem charge (line 29 + line 3)	(line 21 minus line 26) I and observation bed ch		1, 966, 082 0 0	26 27 28 29 30 31
5. 00 5. 00 7. 00 8. 00 9. 00 9. 00 1. 00 2. 00 3. 00 3. 00	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4)	(line 21 minus line 26) d and observation bed ch - line 28)	arges)	1, 966, 082 0 0 0.00000 0.00000 0.00 0.00	26 27 28 29 30 31 32 33
5. 00 5. 00 7. 00 8. 00 9. 00 9. 00 1.	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 mir	(line 21 minus line 26) 4 and observation bed ch - line 28) nus line 33)(see instruc	arges)	1, 966, 082 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00	26 27 28 29 30 31 32 33 34
5.00 5.00 7.00 8.00 9.00	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4)	(line 21 minus line 26) 4 and observation bed ch - line 28) nus line 33)(see instruc	arges)	1, 966, 082 0 0 0.00000 0.00000 0.00 0.00	26 27 28 29 30 31 32 33 34 35
5.00 5.00 7.00 8.00 9.00	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge differential (line 30 + line 4) Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35)	(line 21 minus line 26) I and observation bed ch - line 28) nus line 33)(see instruc ne 31)	arges) ti ons)	1, 966, 082 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00	26 27 28 29 30 31 32 33 34 35 36
<ul> <li>. 00</li> </ul>	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	(line 21 minus line 26) I and observation bed ch - line 28) nus line 33)(see instruc ne 31)	arges) ti ons)	1, 966, 082 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	26 27 28 29 30 31 32 33 34 35 36
<ul> <li>. 00</li> </ul>	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	(line 21 minus line 26) d and observation bed ch - line 28) nus line 33)(see instruc ne 31) and private room cost di	arges) ti ons)	1, 966, 082 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	26 27 28 29 30 31 32 33 34 35 36
<ul> <li>a. 00</li> <li>b. 00</li> <li>c. 00</li> &lt;</ul>	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	(line 21 minus line 26) d and observation bed ch - line 28) nus line 33)(see instruc ne 31) and private room cost di ISTMENTS	arges) ti ons)	1, 966, 082 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	26 27 28 29 30 31 32 33 34 35 36 37
5. 00 7. 00 3. 00 7. 00 3. 00 0. 00 1. 00 2. 00 3. 00 7. 00 3. 00 9. 00 3. 00 9. 00	x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ( PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	(line 21 minus line 26) d and observation bed ch - line 28) nus line 33)(see instruc- ne 31) and private room cost di (STMENTS instructions) 38)	arges) ti ons)	1, 966, 082 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0, 00 0, 00 0, 00 0, 00 0, 00	26 27 28 29 30 31 32 33 34 35 36 37 38 37 38 39

	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2015 To 08/31/2015	Date/Time Pre	epare
				e XVIII	Hospi tal	8/15/2016 3:5 Cost	56 pm
	Cost Center Description	Total Inpatient Costl 1.00	Total	Average Per	Program Days		
2.00	NURSERY (title V & XIX only)	0	0				42.
	Intensive Care Type Inpatient Hospital Units						
8. 00	INTENSIVE CARE UNIT	767, 150	186	4, 124. 4	6 160	659, 914	
. 00	CORONARY CARE UNIT						44.
. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.
	OTHER SPECIAL CARE (SPECIFY)						40.
. 00	Cost Center Description						
						1.00	
. 00	Program inpatient ancillary service cost (Wks					1, 456, 516	
. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	1 through 48)(	see instructio	ins)		3, 047, 874	49.
. 00	Pass through costs applicable to Program inpa	tient routine .	services (from	Wkst D sum	of Parts L and	0	50.
. 00							00.
I. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	0	51.
	and IV)	0 51				-	
2.00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud		lated non nh	cician anasth	atict and	0	
3. 00	medical education costs (line 49 minus line !	5 1	rateu, non-phy		erist, dilu		1 33.
	TARGET AMOUNT AND LIMIT COMPUTATION						
. 00	Program discharges					0	
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00 . 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
. 00	Lesser of lines 53/54 or 55 from the cost rep	orting period (	ending 1996 i	indated and co	mpounded by the	-	
. 00	market basket	bor tring period				0.00	
0. 00	Lesser of lines 53/54 or 55 from prior year (					0.00	
I. 00	If line 53/54 is less than the lower of line					0	61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% or	the target		
2. 00	Relief payment (see instructions)	iisti ucti olis)				0	62
	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST		·				
. 00	Medicare swing-bed SNF inpatient routine cos	s through Dece	mber 31 of the	e cost reporti	ng period (See	310, 914	64
5. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	s after Decemb	er 31 of the c	ost reporting	neriod (See	0	65
. 00	instructions) (title XVIII only)			ost reporting	period (See		/ 03
6.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line d	64 plus line 6	5)(title XVII	l only). For	310, 914	66
	CAH (see instructions)			- · ·		_	
. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	of the cost re	porting period	0	67.
3. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost repo	rting period	0	68.
	(line 13 x line 20)					-	
9.00	Total title V or XIX swing-bed NF inpatient					0	69
00	PART III - SKILLED NURSING FACILITY, OTHER NU					1	1 70
0. 00 . 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	5					70
. 00	Program routine service cost (line 9 x line			2)			72
. 00	Medically necessary private room cost applica		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi	ce costs (line	72 + line 73)				74
. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	lorksheet B, P	art II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ue 2)					76
. 00	Program capital -related costs (line 75 - 11)						77
. 00	Inpatient routine service cost (line 74 minus						78
. 00	Aggregate charges to beneficiaries for excess	• •					79
00	Total Program routine service costs for compa		ost limitatior	ı (line 78 min	us line 79)		80
. 00	Inpatient routine service cost per diem limi		<b>`</b>				81
. 00 . 00	Inpatient routine service cost limitation (li		•				82
. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see ins		3)				84
	Utilization review - physician compensation		ns)				85
. 00	Total Program inpatient operating costs (sum						86
_	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST					
7.00	Total observation bed days (see instructions)					1, 004	
3.00	Adjusted general inpatient routine cost per o	liom (line 07	line 2			649.09	

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2015	Worksheet D-1	
				To 08/31/2015	Date/Time Pre 8/15/2016 3:5	
		Titl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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	246, 278	2, 288, 619	0. 10761	0 651, 686	70, 128	90.00
91.00 Nursing School cost	0	2, 288, 619	0. 00000	0 651, 686	0	91.00
92.00 Allied health cost	0	2, 288, 619	0. 00000	0 651, 686	0	92.00
93.00 All other Medical Education	0	2, 288, 619	0. 00000	0 651, 686	0	93.00

	Financial Systems JASPER COUNTY H ATION OF INPATIENT OPERATING COST	Provider CCN: 151324	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2015 To 08/31/2015	Date/Time Prep 8/15/2016 3:50	
	Cost Conton Description	Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		3, 598	1 1.
. 00	Inpatient days (including private room days, excluding swing-b			3, 029	2.
.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3
00	do not complete this line.	dava)		2,025	
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	2, 025 479	45
00	reporting period	in days) through become		,	
00	Total swing-bed SNF type inpatient days (including private roc	om days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	, davs) through December	31 of the cost	90	7
00	reporting period	ruays) thi ough becember	ST OF THE COST	90	'
00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)			450	
00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	150	9
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	nly (including private r	oom days)	479	10
	through December 31 of the cost reporting period (see instruct		3 /		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	11
2.00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
	through December 31 of the cost reporting period	toniy (merdanig privat	e room days)	0	'`
. 00	Swing-bed NF type inpatient days applicable to titles V or XLX $$	Conly (including privat	e room days)	0	13
. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter 0 on this lin	e)	0	14
. 00		in (excluding swing-bed	uays)	0	
. 00	Nursery days (title V or XIX only)			-	16
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost		17
3. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	129.14	19
0. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
	reporting period				
I. 00	Total general inpatient routine service cost (see instructions			2, 288, 619	
2.00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ (ine 17)	er 31 of the cost report	ing period (line	0	22
3. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23
	x line 18)				
1.00	Swing-bed cost applicable to NF type services through December $7 \times 1$ (ine 19)	31 of the cost reporti	ng period (line	11, 623	24
5. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25
	x line 20)		p	-	
5.00	Total swing-bed cost (see instructions)			322, 537	
7.00	General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		1, 966, 082	27
8. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	l and observation bed ch	arges)	0	28
00	Private room charges (excluding swing-bed charges)		ai gooy	0	
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.00000	31
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 min		tions)	0.00	
. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
b. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fforential (line	0 1 966 082	
. 00	27 minus line 36)	ing private room cost di	inerential (line	1, 966, 082	3/
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
3.00	Adjusted general inpatient routine service cost per diem (see			649.09	
9.00	Program general inpatient routine service cost (line 9 x line			97, 364	
0. 00	Medically necessary private room cost applicable to the Progra			0	40

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST		Provi der	CCN: 151324	Peri od:	Worksheet D-1	
					From 01/01/2015 To 08/31/2015	Date/Time Pre	epare
						8/15/2016 3:5	6 pm
	Cost Center Description	Total	Total	le XIX Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost		Diem (col. 1		(col. 3 x col.	
		1 00	2.00	col. 2) 3.00	4.00	<u>4)</u> 5. 00	
2.00	NURSERY (title V & XIX only)	1.00	2.00		4.00 00 0		42.
	Intensive Care Type Inpatient Hospital Units						
. 00	INTENSIVE CARE UNIT	767, 150	186	4, 124.	46 0	0	
. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
. 00	SURGICAL INTENSIVE CARE UNIT						45
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
. 00	Program inpatient ancillary service cost (Wks		Lino 200)			1.00 162,864	48
. 00	Total Program inpatient costs (sum of lines 4			ns)		260, 228	
. 00	PASS THROUGH COST ADJUSTMENTS			,113)		200, 220	
. 00	Pass through costs applicable to Program inpa	atient routine :	services (from	n Wkst. D, su	m of Parts I and	0	50
. 00	) Pass through costs applicable to Program inc	tiont ancillar	v sorvicos (fi	om Wkst D	cum of Parts II	0	51
. 00	Pass through costs applicable to Program inpa and IV)		y SELVICES (TI	UNI WKSL. D,	Sum OF PAILS II	0	1 31
. 00	Total Program excludable cost (sum of lines 5					0	
8.00	Total Program inpatient operating cost exclud	5 1	lated, non-phy	vsi ci an anest	hetist, and	0	53
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00	Program discharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	orting period	ending 1996 i	indated and c	ompounded by the	0.00	
. 00	market basket	bor tring portiou	chung 1770, t		sinpounded by the	0.00	
. 00	Lesser of lines 53/54 or 55 from prior year of					0.00	
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61
	amount (line 56), otherwise enter zero (see i		s (TTHES 54 X	00), 01 1% 0	i the target		
2. 00	Relief payment (see instructions)					0	62
. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Doco	mbor 21 of the	cost roport	ing pariod (Soo	310, 914	64
. 00	instructions) (title XVIII only)	is through bece		e cost report	ing period (see	510, 914	04
. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the d	ost reportin	g period (See	0	65
	instructions) (title XVIII only)		(			210 014	
o. 00	Total Medicare swing-bed SNF inpatient routir CAH (see instructions)	ne costs (Tine	64 plus line d	5)(title XVI	II only). For	310, 914	00
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 d	of the cost r	eporting period	0	67
	(line 12 x line 19)						
8. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	0	68
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient r	routine costs (	line 67 + line	e 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU						
. 00	Skilled nursing facility/other nursing facili	2			)		70
. 00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine servi	5	•	,			74
. 00	Capital-related cost allocated to inpatient r	routine service	costs (from W	lorksheet B,	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	2)					76
. 00	Program capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minus						78
00	Aggregate charges to beneficiaries for excess	s costs (from p		,			79
00	Total Program routine service costs for compa		ost limitation	n (line 78 mi	nus line 79)		80
00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li		)				81
. 00	Reasonable inpatient routine service cost (s						83
. 00	Program inpatient ancillary services (see ins						84
	Utilization review - physician compensation (						85
. 00	Total Program inpatient operating costs (sum		rough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					1, 004	87
	Adjusted general inpatient routine cost per o		line 2)			649.09	
3. 00							

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 01/01/2015 To 08/31/2015	Date/Time Pre 8/15/2016 3:5	
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(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	246, 278	2, 288, 619	0. 10761	0 651, 686	70, 128	90.00
91.00 Nursing School cost	0	2, 288, 619	0.00000	0 651, 686	0	91.00
92.00 Allied health cost	0	2, 288, 619	0.00000	0 651, 686	0	92.00
93.00 All other Medical Education	0	2, 288, 619	0.00000	0 651, 686	0	93.00

Health Financial Systems JASPER COUNTY HOS	PI TAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151324	Peri od:	Worksheet D-3	
			From 01/01/2015		
			To 08/31/2015		
	T: +1	- \0/1.1.1	11	8/15/2016 3:5	6 pm
Cont Conton Deceminting	11 11	e XVIII	Hospital	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
30. 00 03000 ADULTS & PEDI ATRI CS		1	1, 057, 075		30.00
31. 00  03100   INTENSI VE CARE UNI T			208, 000		31.00
41. 00  04100  SUBPROVIDER - IRF					41.00
			0		•
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 5739	18 403, 101	231, 347	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 4229			•
57. 00 05700 CT SCAN		0.0000		0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)		0.0000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	59.00
60. 00 06000 LABORATORY		0. 2820		165, 795	•
60. 01 06001 BLOOD LABORATORY		0.0000	0 00	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 5514		24, 908	•
65. 00 06500 RESPI RATORY THERAPY		0. 5866	40 709, 156	416, 019	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 8201	21 56, 880	46, 648	66.00
66.01 06601 KV HEALTH PT		1. 1650	19 0	0	66.01
67.00 06700 OCCUPATI ONAL THERAPY		2.3915	62 31, 980	76, 482	67.00
67. 01 06701 KV HEALTH OT		1. 8705	39 0	0	67.01
68.00 06800 SPEECH PATHOLOGY		2. 3272	44 8, 140	18, 944	68.00
68. 01 06801 KV HEALTH ST		2.1295	63 0	0	68.01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000	0 00	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4070	60 64, 995	26, 457	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 4571			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4217			•
OUTPATIENT SERVICE COST CENTERS					1
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
88. 03 08801 RURAL HEALTH CLINIC IV		0.0000		0	88.03
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	89.00
90. 00 09000 CLINIC		0. 6162		-	
91. 00 09100 EMERGENCY		1. 1533			•
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6583		0	
93. 00 04040 FAMILY PRACTICE		0.0000		0	93.00
200.00 Total (sum of lines 50-94 and 96-98)		0.0000	2, 935, 440		
201.00 Less PBP Clinic Laboratory Services-Program only charges (	line 61)		2, 933, 440	1, 400, 010	200.00
202.00 Net Charges (Line 200 minus Line 201)			2, 935, 440		201.00
		I	2, 755, 440	I	1202.00

Health Financial Systems JASP	PER COUNTY HOSPITAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151324	Peri od:	Worksheet D-3	;
			From 01/01/2015		
	Component	CCN: 15Z324	To 08/31/2015	Date/Time Pre	
	Ti +1	e XVIII	Swing Beds - SNF	8/15/2016 3:5 Cost	o pili
Cost Center Description		Ratio of Cos		Inpatient	
cost center bescription		To Charges		Program Costs	
		TO charges	Charges	$(col \cdot 1 \times col \cdot)$	
			onar ges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
41. 00 04100 SUBPROVI DER – I RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVICE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM		0. 5739	18 2, 923	1, 678	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 42292		2, 424	
57. 00  05700  CT_SCAN		0. 4229		2,424	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0	
				0	
		0.0000		-	
		0. 2820			
60. 01 06001 BLOOD LABORATORY		0.0000		0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 5514			
65. 00 06500 RESPI RATORY THERAPY		0. 5866		80, 723	
66. 00 06600 PHYSI CAL THERAPY		0. 82012			
66. 01 06601 KV HEALTH PT		1. 1650		0	
67. 00 06700 OCCUPATI ONAL THERAPY		2.3915			
67.01 06701 KV HEALTH OT		1.8705		0	
68.00 06800 SPEECH PATHOLOGY		2. 3272		1, 292	
68. 01 06801 KV HEALTH ST		2. 1295	63 0	0	68.01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000	00 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4070	60 744	303	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 45712	28 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 42178	87 113, 900	48, 042	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
88.03 08801 RURAL HEALTH CLINIC IV		0.0000	00	0	88.03
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000	00	0	89.00
90. 00 09000 CLINIC		0. 6162	65 224	138	90.00
91. 00 09100 EMERGENCY		1. 1533	99 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6583	66 0	0	92.00
93. 00 04040 FAMILY PRACTICE		0.0000	00 00	0	93.00
200.00 Total (sum of lines 50-94 and 96-98)			374, 209	257, 153	
	nly charges (line 41)	1	0		
201.00 Less PBP Clinic Laboratory Services-Program o	III y Charges (Time of)		0		201.00

Health Financial Systems JASPER C	OUNTY HOSPITAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151324	Peri od:	Worksheet D-3	
			From 01/01/2015		
			To 08/31/2015		
	T: +		11	8/15/2016 3:5	6 pm
Cast Conton Description	II L	le XIX	Hospital	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1	138, 628		30.00
31. 00 03100 I NTENSI VE CARE UNI T			25, 962		31.00
41. 00 04100 SUBPROVIDER - IRF					1
			0		41.00
42. 00 04200 SUBPROVI DER			0		
43.00 04300 NURSERY			0		43.00
ANCI LLARY SERVI CE COST CENTERS		0 5700	10 01 017	10.004	
50.00 OSOOO OPERATING ROOM		0.5739		12, 234	1
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
54. 00 O5400 RADI OLOGY-DI AGNOSTI C		0. 4229		12, 113	1
57.00 05700 CT SCAN		0.0000		0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
60. 00 06000 LABORATORY		0. 2820		22, 403	1
60. 01 06001 BLOOD LABORATORY		0.0000		0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 5514		3, 400	
65. 00 06500 RESPI RATORY THERAPY		0. 5866	40 60, 559	35, 526	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 8201	21 9, 453	7, 753	66.00
66. 01 06601 KV HEALTH PT		1. 1650	19 0	0	66.01
67. 00 06700 OCCUPATI ONAL THERAPY		2.3915	62 0	0	67.00
67.01 06701 KV HEALTH OT		1. 8705	39 0	0	67.01
68.00 06800 SPEECH PATHOLOGY		2. 3272	44 0	0	68.00
68. 01 06801 KV HEALTH ST		2. 1295	63 0	0	68.01
70.00 07000 ELECTROENCEPHALOGRAPHY		0.0000	00 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4070		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 4571		1, 920	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4217		46, 071	1
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		1. 5515	0 00	0	88.00
88.03 08801 RURAL HEALTH CLINIC IV		1. 4337		0	1
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90. 00 09000 CLINIC		0. 6162		3, 747	
91. 00 09100 EMERGENCY		1. 1533			1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6583		5, 387	
93. 00 04040 FAMILY PRACTICE		0.0000		0	
200.00 Total (sum of lines 50-94 and 96-98)		0.0000	343, 933		
201.00 Less PBP Clinic Laboratory Services-Program only (	charges (line 61)		343, 933	102,004	200.00
202.00 Net Charges (line 200 minus line 201)	sharges (The OI)		343, 933		201.00
202.00 [met ond ges (The 200 minus The 201)		I	545, 755	I	202.00

	Financial Systems JASPER COUNTY HOS ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151324 Title XVIII	Peri od: From 01/01/2015 To 08/31/2015 Hospi tal	u of Form CMS-2 Worksheet E Part B Date/Time Prep 8/15/2016 3:50 Cost	pared:
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
00	Medical and other services (see instructions)			4, 607, 900	1.00
00	Medical and other services reimbursed under OPPS (see instructio	ons)		0	2.00
00	PPS payments			0	3.00
00	Outlier payment (see instructions)			0	4.00
00	Enter the hospital specific payment to cost ratio (see instructi	ons)		0.000	5.00
00 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0. 00	6.00 7.00
00	Transitional corridor payment (see instructions)			0.00	8.00
00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		Ő	9.00
. 00	Organ acqui si ti ons			0	10.00
. 00	Total cost (sum of lines 1 and 10) (see instructions)			4, 607, 900	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
~~	Reasonable charges				10.00
	Ancillary service charges	× 40)		0	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line Total reasonable charges (sum of lines 12 and 13)	5 07)		0	13.00 14.00
. 00	Customary charges			0	14.00
. 00	Aggregate amount actually collected from patients liable for pay	ment for services on	a charge basis	0	15.00
	Amounts that would have been realized from patients liable for p			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)				
. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.00000	17.00
	Total customary charges (see instructions)	if line 10 evenede li	no 11) (coo	0	18.00
. 00	Excess of customary charges over reasonable cost (complete only instructions)	IT TIME 18 exceeds TI	ne II) (see	0	19.0
. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 0
	instructions)		10 10) (000		20.0
. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see i	nstructions)		4, 653, 979	21.0
	Interns and residents (see instructions)			0	22. 0
	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	23.00
. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24.00
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			52, 240	25.00
	Deductibles and Coinsurance relating to amount on line 24 (for C	CAH see instructions)		1, 370, 909	26.0
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu			3, 230, 830	
	instructions)				
	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28.0
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.0
	Subtotal (sum of lines 27 through 29) Primary payer payments			3, 230, 830 2, 408	
	Subtotal (line 30 minus line 31)			3, 228, 422	
. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)		0, 220, 122	02.0
. 00	Composite rate ESRD (from Wkst. I-5, line 11)	,		0	33.0
	Allowable bad debts (see instructions)			190, 369	
	Adjusted reimbursable bad debts (see instructions)			123, 740	
. 00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		190, 020	36.0
	Subtotal (see instructions)			3, 352, 162	37.0
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38.0 39.0
. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.0
. 98	Partial or full credits received from manufacturers for replaced	l devices (see instruc	tions)	0	39.9
	RECOVERY OF ACCELERATED DEPRECIATION			0	39.9
	Subtotal (see instructions)			3, 352, 162	40. 0
. 99 . 00	Sequestration adjustment (see instructions)			67, 043	
. 99 . 00 . 01				3, 301, 966	
. 99 . 00 . 01 . 00	Interim payments				42.0
. 99 . 00 . 01 . 00 . 00	Interim payments Tentative settlement (for contractors use only)			0 -16 847	12 0
. 99 . 00 . 01 . 00 . 00 . 00	Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions)	with CMS Pub 15-2	chapter 1	-16, 847	
. 99 . 00 . 01 . 00 . 00 . 00	Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,		
. 99 . 00 . 01 . 00 . 00 . 00	Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions)	e with CMS Pub. 15-2,	chapter 1,	-16, 847	43.00 44.00
. 99 . 00 . 01 . 00 . 00 . 00 . 00	Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	e with CMS Pub. 15-2,	chapter 1,	-16, 847 0 0	44. 0 90. 0
. 99 . 00 . 01 . 00 . 00 . 00 . 00	Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)	e with CMS Pub. 15-2,	chapter 1,	-16, 847 0 0 0 0	44. 0 90. 0 91. 0
. 99 . 00 . 01 . 00 . 00 . 00 . 00 . 00 . 00	Interim payments Tentative settlement (for contractors use only) Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance §115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	e with CMS Pub. 15-2,	chapter 1,	-16, 847 0 0 0 0	44. 0 90. 0 91. 0 92. 0

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 151324	Period: From 01/01/2015 To 08/31/2015		pared
		Ti tl	e XVIII	Hospi tal	Cost	
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider 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 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate		2, 485, 9	75 0	3, 227, 666 0	1. 2. 3.
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01 02 03 04 05	ADJUSTMENTS TO PROVIDER	07/22/2015	125, 0	00 07/22/2015 0 0 0 0	74, 300 0 0 0 0	3. 3. 3.
	Provider to Program	1	r	-	-	
50 51 52 53 54	ADJUSTMENTS TO PROGRAM			0 0 0 0		3. 3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		125, 0	00	74, 300	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 610, 9	75	3, 301, 966	4.
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	1				5
0	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	5
)2				0	0	
3				0	0	5
- ^	Provider to Program			0		_
50 51	TENTATI VE TO PROGRAM			0	0	5
52				0	0	5
9	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1	SETTLEMENT TO PROVIDER		91, 5	99	0	6
02	SETTLEMENT TO PROGRAM			0	16, 847	6
00	Total Medicare program liability (see instructions)		2, 702, 5		3, 285, 119	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
			)	1.00	2.00	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED			Period: From 01/01/2015		
		component	t CCN: 15Z324	To 08/31/2015	Date/Time Pre 8/15/2016 3:5	
		Titl	e XVIII S	Swing Beds - SNF	Cost	
		Inpatier	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider 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		554, 36	9	0	
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) Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3.01
3.02				0	0	
3.03				0	0	
3.04 3.05				0	0	
3.05	Provider to Program			0	0	3.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	
3.52				0	0	3.52
3.53 3.54				0	0	3.53 3.54
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		
0.77	3. 50-3. 98)					
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)		554, 36	9	0	4.00
	TO BE COMPLETED BY CONTRACTOR	-	1			
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) Program to Provider					5.00
5.01	TENTATI VE TO PROVIDER			0	0	5.01
5.02				0	0	
5.03				0	0	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.50 5.51
5.51 5.52				0		
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	
	5. 50-5. 98)			-	_	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		7, 74	9	0	•
6.02	SETTLEMENT TO PROGRAM		F/0.11	0	0	
7.00	Total Medicare program liability (see instructions)		562, 11	8 Contractor	0 NPR Date	7.00
			0	Number 1.00	(Mo/Day/Yr) 2.00	
8.00	Name of Contractor		0	1.00	2.00	8.00

Heal th	Financial Systems JASPER COUNTY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151324	Period: From 01/01/2015 To 08/31/2015		
		Title XVIII	Hospi tal	Cost	
	F			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst		14	0	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12		0	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			0	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		0	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			0	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3			0	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0	8,00
9,00	Sequestration adjustment amount (see instructions)			0	9,00
10,00	Calculation of the HIT incentive payment after sequestration	n (see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		I		
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	s)	0	32.00

<u>Heal th</u>	Financial Systems	JASPER COUNTY HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING E	BEDS	Provider CCN: 1513 Component CCN: 15Z		Period: From 01/01/2015 To 08/31/2015	Worksheet E-2 Date/Time Pre	
			•	324	10 08/31/2015	8/15/2016 3:5	
			Title XVIII	0	<u>Swing Beds - SNF</u>		
					Part A	Part B	
	CONDUTATION OF NET COST OF CONFERENCED VICE	<u> </u>			1.00	2.00	
1.00	COMPUTATION OF NET COST OF COVERED SERVICES				314, 023	0	1.00
2.00	Inpatient routine services - swing bed-skr Inpatient routine services - swing bed-NF (				314, 023	0	2.00
2.00	Ancillary services (from Wkst. D-3, col. 3,		A and sum of Wkst	n	259, 725	0	3.00
3.00	Part V, cols. 6 and 7, line 202, for Part E			υ,	237, 723	0	3.00
4.00	Per diem cost for interns and residents not					0.00	4.00
1.00	instructions)					0.00	1.00
5.00	Program days				479	0	5.00
6.00	Interns and residents not in approved teach	ning program (see ins	structions)			0	6.00
7.00	Utilization review - physician compensation				0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lir	nes 6 and 7)	3		573, 748	0	8.00
9.00	Primary payer payments (see instructions)				0	0	9.00
10.00	Subtotal (line 8 minus line 9)				573, 748	0	10.00
11.00	Deductibles billed to program patients (exc	clude amounts applica	able to physician		0	0	11.00
	professional services)						
12.00	Subtotal (line 10 minus line 11)				573, 748	0	12.00
13.00	Coinsurance billed to program patients (fro for physician professional services)	om provider records)	(exclude coinsuranc	e	158	0	
14.00	80% of Part B costs (line 12 x 80%)					0	
15.00	Subtotal (enter the lesser of line 12 minus		4)		573, 590		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI				0	0	
16.50	Pioneer ACO demonstration payment adjustmer	nt (see instructions)	)		0	0	10100
16.55	410A RURAL DEMONSTRATION PROJECT				0		16.55
17.00	Allowable bad debts (see instructions)				0	-	17.00
17.01	Adjusted reimbursable bad debts (see instru				0	0	
18.00	Allowable bad debts for dual eligible benef	ficiaries (see instru	uctions)		570 500	0	
19.00	Total (see instructions)				573, 590	0	19.00 19.01
19. 01 20. 00	Sequestration adjustment (see instructions) Interim payments	1			11, 472 554, 369	0	20.00
20.00	Tentative settlement (for contractor use or				554, 369	0	20.00
21.00	Balance due provider/program (line 19 minus		ad 21)		7, 749	0	21.00
22.00	Protested amounts (nonallowable cost report			.2	7,749	0	22.00
23.00	chapter 1, §115.2		Se with GWB FUD. 19-	<b>Z</b> ,	0	0	23.00

	Financial Systems JASPER COUN			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151324	Peri od:	Worksheet E-3	
			From 01/01/2015 To 08/31/2015	Part V Date/Time Pre	nared
			10 00/31/2013	8/15/2016 3:5	
		Title XVIII	Hospi tal	Cost	
				1.00	
1.00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDIC.	ARE PART A SERVICES - CUST	REIMBURSEMENT	3, 047, 874	1.00
2.00	Nursing and Allied Health Managed Care payment (see instru	ictions)		3, 047, 874	
3.00	Organ acquisition			0	
4.00	Subtotal (sum of lines 1 through 3)			3, 047, 874	
5.00	Primary payer payments			4, 023	
6.00	Total cost (line 4 less line 5). For CAH (see instructions	)		3, 074, 330	
	COMPUTATION OF LESSER OF COST OR CHARGES	/			1
	Reasonabl e charges				
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	
9.00	Organ acquisition charges, net of revenue			0	
10.00	Total reasonable charges			0	10.00
11 00	Customary charges				1 4 4 9 6
11.00	Aggregate amount actually collected from patients liable f			0	
12.00	Amounts that would have been realized from patients liable had such payment been made in accordance with 42 CFR 413.1		n a charge basis	0	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	3(e)		0.000000	13.00
14.00	Total customary charges (see instructions)			0.000000	
15.00	Excess of customary charges over reasonable cost (complete	only if line 14 exceeds li	ne 6) (see	0	
	instructions)			Ũ	
16.00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds lin	e 14) (see	0	16.00
	instructions)				
17.00	Cost of physicians' services in a teaching hospital (see i	nstructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	<b>E</b> ( ) ( )			
18.00	Direct graduate medical education payments (from Worksheet	E-4, line 49)		0	
19.00	Cost of covered services (sum of lines 6, 17 and 18)			3, 074, 330	
20.00	Deductibles (exclude professional component) Excess reasonable cost (from line 16)			332, 172 0	
21.00	Subtotal (line 19 minus line 20 and 21)			2, 742, 158	
23.00	Coi nsurance			2, 742, 150	
24.00	Subtotal (line 22 minus line 23)			2, 739, 953	
25.00	Allowable bad debts (exclude bad debts for professional se	rvices) (see instructions)		27, 347	
26.00	Adjusted reimbursable bad debts (see instructions)			17, 776	
27.00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		27, 347	
28.00	Subtotal (sum of lines 24 and 25, or line 26)	,		2, 757, 729	28.00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instruct	i ons)		0	29.50
29. 99	Recovery of Accel erated Depreciation			0	
30.00	Subtotal (see instructions)			2, 757, 729	
30. 01	Sequestration adjustment (see instructions)			55, 155	
	Interim payments			2, 610, 975	
32.00	Tentative settlement (for contractor use only)			0	
33.00	Balance due provider/program (line 30 minus lines 30.01, 3			91, 599	
34.00	Protested amounts (nonallowable cost report items) in acco	rdance with CMS Pub. 15-2,	cnapter 1,	0	34.00

MCRI F32 - 9.2.159.0

ALCUL	Financial Systems JASPER COUNTY HOSE ATION OF RELMBURSEMENT SETTLEMENT	Provider CCN: 151324	Period:	Worksheet E-3	
			From 01/01/2015 To 08/31/2015	Part VII Date/Time Prep 8/15/2016 3:50	
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
		TES FOD TITLES V OD V		2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC COMPUTATION OF NET COST OF COVERED SERVICES	ES FUR TITLES V UR A	IX SERVICES		-
.00	Inpatient hospital/SNF/NF services		260, 228		1 1.
00	Medical and other services		2007220	0	
00	Organ acquisition (certified transplant centers only)		0		3.
00	Subtotal (sum of lines 1, 2 and 3)		260, 228	0	
00	Inpatient primary payer payments		0	_	5
00	Outpatient primary payer payments			0	
00	Subtotal (line 4 less sum of lines 5 and 6)		260, 228	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				-
00	Routi ne servi ce charges		164, 590		8
00	Ancillary service charges		343, 933	0	
	Organ acquisition charges, net of revenue		0	-	10
I. 00	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		508, 523	0	12
	CUSTOMARY CHARGES				
3.00	Amount actually collected from patients liable for payment for se	ervices on a charge	0	0	13
. 00	basis Amounts that would have been realized from patients liable for $\boldsymbol{p}$	on O	0	14	
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	
5.00 7.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	flips 16 overade	508, 523 248, 295	0	
. 00	line 4) (see instructions)	I TITLE TO exceeds	240, 295	0	''
3. 00	Excess of reasonable cost over customary charges (complete only	fline 4 exceeds lir	ne 0	0	18
	16) (see instructions)				
9.00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see instruc	tions)	0	0	
I. 00	Cost of covered services (enter the lesser of line 4 or line 16)		260, 228	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be con	npleted for PPS provi			
	Other than outlier payments		0	0	
	Outlier payments		0	0	23
	Program capital payments Capital exception payments (see instructions)		0		22
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	28
9.00	Titles V or XIX (sum of lines 21 and 27)		260, 228	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		260, 228	0	
	Deductibles		0	0	
	Coinsurance Allowable bad debts (see instructions)		0	-	34
	Utilization review	0	0	35	
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	260, 228	0		
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0		
8. 00	Subtotal (line 36 ± line 37)	260, 228	0		
9.00	Direct graduate medical education payments (from Wkst. E-4)		0		39
0. 00	Total amount payable to the provider (sum of lines 38 and 39)		260, 228	0	40
	Interim payments		304, 830	0	
2.00	Balance due provider/program (line 40 minus line 41)		-44, 602	0	
3.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Dub 15 2		0	43

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column onl		CCN: 151324	Period: From 01/01/2015	Worksheet G	
i una- i	ype accounting records, comprete the General Fund cordinin on	y)		To 08/31/2015	Date/Time Pre 8/15/2016 3:5	
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	0		0 0	0	
2.00 3.00	Temporary i nvestments Notes receivable			0 0	0	
4.00	Accounts receivable	0		0 0	0	
5.00	Other receivable	C		0 0	0	
5.00	Allowances for uncollectible notes and accounts receivable	C		0 0	0	6.00
7.00	Inventory	C		0 0	0	
3.00	Prepaid expenses	0		0 0	0	
9.00	Other current assets Due from other funds	0		0 0	0	
10.00 11.00	Total current assets (sum of lines 1-10)			0 0	0	
11.00	FIXED ASSETS			0 0	0	11.00
12.00	Land	C		0 0	0	12.00
13.00	Land improvements	C		0 0	0	13.00
14.00	Accumulated depreciation	C		0 0	0	14.00
15.00	Buildings	0		0 0	0	
16.00	Accumulated depreciation	0		0 0	0	
17.00 18.00	Leasehold improvements Accumulated depreciation			0 0	0	
19.00	Fixed equipment			0 0	0	
20.00	Accumulated depreciation	C C		0 0	0	
21.00	Automobiles and trucks	0		0 0	0	
22.00	Accumul ated depreciation	C		0 0	0	22.00
23.00	Major movable equipment	C		0 0	0	
	Accumulated depreciation	0		0 0	0	
25.00	Minor equipment depreciable	0		0 0	0	
26.00 27.00	Accumulated depreciation HIT designated Assets			0 0	0	
28.00	Accumulated depreciation			0 0	0	
29.00	Mi nor equi pment-nondepreci abl e	C C		0 0	0	
30.00	Total fixed assets (sum of lines 12-29)	C		0 0	0	30.00
	OTHER ASSETS		1	-		
31.00	Investments	0		0 0	0	
32.00	Deposits on leases Due from owners/officers			0 0	0	
33.00 34.00	Other assets			0 0	0	
35.00	Total other assets (sum of lines 31-34)			0 0	0	
36.00	Total assets (sum of lines 11, 30, and 35)	C		0 0	0	
	CURRENT LI ABI LI TI ES					
	Accounts payable	C		0 0	0	
38.00	Salaries, wages, and fees payable	0		0 0	0	
39.00	Payroll taxes payable	0		0 0	0	
40.00	Notes and loans payable (short term) Deferred income			0 0	0	1 .0.00
42.00	Accelerated payments			0 0	0	41.00
43.00	Due to other funds	C C		0 0	0	
44.00	Other current liabilities	0		0 0	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	C		0 0	0	45.00
	LONG TERM LIABILITIES		1			
46.00	Mortgage payable	0		0 0	0	
47.00	Notes payable	0		0 0	0	
48.00 49.00	Unsecured Loans Other Long term Liabilities			0 0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	0		0 0	0	
51.00	Total liabilities (sum of lines 45 and 50)	C C		0 0	0	
	CAPI TAL ACCOUNTS					
52.00	General fund balance	0				52.00
53.00	Specific purpose fund			0		53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00 56.00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55.00
56.00 57.00	Plant fund balance - invested in plant			0	0	
58.00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	
59.00	Total fund balances (sum of lines 52 thru 58)	0		0 0	0	
50.00	Total liabilities and fund balances (sum of lines 51 and			0 0	0	60.00

Heal th	Financial Systems	JASPER COUNTY	/ HOSPI TAL			In Lie	u of Form CMS-	2552-10
	ENT OF CHANGES IN FUND BALANCES			CCN: 151324		eriod: com 01/01/2015	Worksheet G-1 Date/Time Pre 8/15/2016 3:5	epared:
		General	Fund	Speci al	Pur	pose Fund	Endowment Func	
		1.00	0.00	0.00		4.00	5.00	
1.00	Fund balances at beginning of period	1.00	2.00 8,267,284	3.00		4.00	5.00	1.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) LTC RECONCILING ITEM	320, 547 0 0 0 0 0	-3, 012, 057 5, 255, 227		0 0 0 0	0		2.00 3.00 4.00 5.00 6.00 7.00 8.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) TRANSFER TO FRANCISCANS Total deductions (sum of lines 12-17) Fund balance at end of period per balance	5, 575, 774 0 0 0 0 0 0	320, 547 5, 575, 774 5, 575, 774 5, 575, 774 0		0 0 0 0 0	0 0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00
	sheet (line 11 minus line 18)	Endowment Fund	PLant	Fund				
1 00	Fund halanasa at haginning of namind	6.00	7.00	8.00	0			1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) LTC RECONCILING ITEM	0			0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) TRANSFER TO FRANCISCANS Total deductions (sum of lines 12-17) Fund balance at end of period per balance	000			0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19.00

Heal th	Financial Systems JASPER COUNTY HO	SPI TAL		In Lie	eu of Form CMS-2	2552-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 151324	Period: From 01/01/2015 To 08/31/2015		pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES General Inpatient Routine Services					-
1.00	Hospi tal		1, 804, 4	00	1, 804, 400	1.00
2.00	SUBPROVI DER – I PF		1,004,4	00	1, 004, 400	2.00
3.00	SUBPROVIDER - IRF			0	0	
4.00	SUBPROVIDER			0	0	1
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		1, 804, 4	00	1, 804, 400	10.00
11 00	Intensive Care Type Inpatient Hospital Services		349, 6	FO	349, 650	11 00
11.00 12.00	CORONARY CARE UNIT		349, 0	50	349, 650	11.00 12.00
12.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of I	i nes	349, 6	50	349, 650	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		2, 154, 0		2, 154, 050	
18.00	Ancillary services		4, 667, 1			1
19.00	Outpatient services		132, 6			
20.00	RURAL HEALTH CLINIC			0 180, 018		
20.03	RURAL HEALTH CLINIC IV			0 271, 591		1
21.00 22.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY			0 0		
22.00	AMBULANCE SERVICES			1, 089, 280	1, 089, 280	22.00
23.00	CMHC					23.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE			0 494, 986	494, 986	26.00
27.00	OTHER NRCC		586, 3	45 1, 139, 410	1, 725, 755	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	7, 540, 1	74 25, 687, 368	33, 227, 542	28.00
	G-3, line 1)					
20.00	PART II - OPERATING EXPENSES		1	22 (44 202	1	20.00
29.00 30.00	Operating expenses (per Wkst. A, column 3, line 200)			23, 644, 202		29.00 30.00
30.00				0		30.00
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)			C		36.00
37.00	OTHER			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00 42.00	Total deductions (sum of lines 37-41)			0		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		23, 644, 202		42.00
.5. 00	to Wkst. G-3, line 4)	(1. 0. 01 01		20, 011, 202		
	• • • •		•		•	•

Heal th	Financial Systems	JASPER COUNTY HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN:	151324	Peri od:	Worksheet G-3	
					From 01/01/2015 To 08/31/2015	Date/Time Pre	norod.
					To 08/31/2015	8/15/2016 3:5	
						0/10/2010 010	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Part	I, column 3, line 2	28)			33, 227, 542	1.00
2.00	Less contractual allowances and discounts on	patients' accounts				12, 887, 105	2.00
3.00	Net patient revenues (line 1 minus line 2)					20, 340, 437	3.00
4.00	Less total operating expenses (from Wkst. G-2	, Part II, line 43)	)			23, 644, 202	4.00
5.00	Net income from service to patients (line 3 m	inus line 4)				-3, 303, 765	5.00
	OTHER INCOME						
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					1, 292	7.00
8.00	Revenues from telephone and other miscellaneo	us communication se	ervi ces			0	8.00
9.00	Revenue from television and radio service					0	9.00
10.00						0	10.00
11.00						0	11.00
12.00	J J J J J J J J J J J J J J J J J J J					0	12.00
13.00	Revenue from Laundry and Linen service					0	13.00
14.00	Revenue from meals sold to employees and gues	ts				0	14.00
15.00	Revenue from rental of living quarters					0	15.00
16.00			n patients			0	16.00
17.00						0	17.00
18.00						0	18.00
	Tuition (fees, sale of textbooks, uniforms, e					0	19.00
	Revenue from gifts, flowers, coffee shops, an	d canteen				0	20.00
	Rental of vending machines					0	21.00
	Rental of hospital space					0	22.00
23.00						0	23.00
	OTHER REVENUE					290, 416	
	Total other income (sum of lines 6-24)					291, 708	
	Total (line 5 plus line 25)					-3, 012, 057	
	OTHER EXPENSES (SPECIFY)	orinte)				0	27.00 28.00
	Total other expenses (sum of line 27 and subs Net income (or loss) for the period (line 26					-	
29.00	Iner income (or ross) for the period (The 26	minus IIne 20)			I	-3, 012, 057	29.00

	inancial Systems 5 OF PROVIDER-BASED HOME HEALT	H AGENCY COSTS	JASPER COUNT		CCN: 151324 F	Peri od:	u of Form CMS-2 Worksheet H	2002
				HHA CCN:	F	From 01/01/2015 Fo 08/31/2015	Date/Time Pre 8/15/2016 3:5	
						Home Health	PPS	
		Sal ari es	Employee	Transportati on	Contracted / Ruy	Agency I Other Costs	Total (sum of	
		54141163	Benefits	(see	chased	other costs	cols. 1 thru	
				instructions)	Servi ces		5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	ENERAL SERVICE COST CENTERS				1			
	apital Related - Bldg. &			0		0	0	1.
	ixtures						0	
	apital Related – Movable quipment			0		0	0	2.
	lant Operation & Maintenance	0	0	0		0	0	3.
	ransportation	0	0	0		0 0	0	4.
	dministrative and General	252, 801	0	-		122, 416	375, 217	
	HA REIMBURSABLE SERVICES		-	-	-	,		
	killed Nursing Care	475, 303	0	0	(	0 0	475, 303	6
00 Pł	hysical Therapy	0	0	0	(	0 0	0	7.
	ccupational Therapy	0	0	0	0	0 0	0	
	peech Pathology	0	0	0		0 0	0	9
	edical Social Services	36, 574	0	0		0	36, 574	
	ome Health Aide	133, 249	0	0		0	133, 249	
	upplies (see instructions)	0	0				0	
	rugs ME	0					0	
	HA NONREI MBURSABLE SERVI CES	0	0	0	<u> </u>	0	0	14
	ome Dialysis Aide Services	0	0	0	(	0 0	0	15
	espiratory Therapy	0	0	0		0 0	0	
	rivate Duty Nursing	0	0	o o		0 0	0	
	linic	0	0	0	(	0 0	0	
. 00 He	ealth Promotion Activities	0	0	0		0 0	0	19
. 00 Da	ay Care Program	0	0	0	0	0 0	0	20
	ome Delivered Meals Program	0	0	0	(	0 0	0	21
	omemaker Service	0	0	0	0	0 0	0	22
	II Others (specify)	37,070	0	0	(	5	37,070	
1. 00 To	otal (sum of lines 1-23)	934, 997	U Declarcified	0 Adiustmente	Not Experses	0 122, 416	1,057,413	3 24
		Reclassificati on	Reclassified Trial Balance	Adjustments	Net Expenses for Allocation			
		UII	(col. 6 +		$(col \cdot 8 + col \cdot$			
			col.7)		9)			
		7.00	8.00	9.00	10.00			
	ENERAL SERVICE COST CENTERS	-	-	-		-1		ł.,
	apital Related - Bldg. &	0	0	0	(			1
	ixtures	0	0					2
	apital Related – Movable quipment	0	0	0		J		2
	lant Operation & Maintenance	0	0	0	0	2 C		3
	ransportation	0	0	o o				4
	dministrative and General	-11, 882	363, 335	0	363, 335	5		5
	HA REIMBURSABLE SERVICES							1
	killed Nursing Care	-25, 376	449, 927	0	449, 92	7		6
	hysical Therapy	0	0	0	0	C		7
	ccupational Therapy	0	0	0	(	D		8
	peech Pathology	0	0	0	(	D		9
	edical Social Services	-34, 745			1, 829			10
	ome Health Aide	-2, 665	130, 584 0		130, 584	4		11
	upplies (see instructions) rugs	0	0	-				12
	ME	0	0	-				14
	HA NONREI MBURSABLE SERVI CES			. 0		-		1
. 00 DA	ome Dialysis Aide Services	0	0	0	(			15
. 00 DN HH	one brarysi's Arde Services		0	0		D		16
. 00 DM HH . 00 Ho	espiratory Therapy	0	1	0		D		17
. 00 DM HH . 00 Hc . 00 Re		0	0		1			18
. 00 DM HH . 00 Ho . 00 Re . 00 Pr	espiratory Therapy rivate Duty Nursing	0	0	0	(	J		
. 00 DM HH . 00 Hc . 00 Re . 00 Pr . 00 CI . 00 He	espiratory Therapy rivate Duty Nursing linic ealth Promotion Activities	0 0 0 0	0 0 0	0	(			19
A. 00         DM           HH         HH           5. 00         HG           5. 00         Re           7. 00         Pr           8. 00         CI           9. 00         He           0. 00         Data	espiratory Therapy rivate Duty Nursing linic ealth Promotion Activities ay Care Program		0 0 0	0	0			19 20
I.         OO         DM           5.         00         Hd           5.         00         Re           7.         00         Pr           8.         00         CI           9.         00         He           9.         00         Date           1.         00         He	espiratory Therapy rivate Duty Nursing linic ealth Promotion Activities ay Care Program ome Delivered Meals Program		0 0 0 0 0	0 0 0	0			19 20 21
4.00         DM           5.00         Hd           5.00         Rd           5.00         Rd           7.00         Pr           3.00         CI           9.00         Hd           0.00         Da           1.00         Hd           2.00         Hd	espiratory Therapy rivate Duty Nursing linic ealth Promotion Activities ay Care Program ome Delivered Meals Program omemaker Service			0	(			19 20 21 22
A.         OO         DM           6.         00         He           6.         00         He           6.         00         Pr           8.         00         CI           9.         00         He           9.         00         Da           9.         00         He           9.         00         He	espiratory Therapy rivate Duty Nursing linic ealth Promotion Activities ay Care Program ome Delivered Meals Program	0 0 0 0 -29, 016 -103, 684			( ( ( 8, 054	2 2 4		19 20 21

	Financial Systems LLOCATION - HHA GENERAL SERVICE	C05T	JASPER COUNTY		CCN: 151224	Period:	u of Form CMS-	
CUSTA	LLUCATION - HHA GENERAL SERVICE	COST		HHA CCN:	CCN: 151324 157149	From 01/01/2015 To 08/31/2015	Worksheet H-1 Part I Date/Time Pre 8/15/2016 3:5	pared:
						Home Health	PPS	
			Capital Rela	ated Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fi xtures	Movable Equipment	Plant Operation & Maintenance		Subtotal (col s. 0-4)	-
		0	1.00	2.00	3.00	4.00	4A. 00	
1 00	GENERAL SERVICE COST CENTERS	0	0					1 00
1.00 2.00	Capital Related - Bldg. & Fixtures Capital Related - Movable	0	0	0			C C	
3.00	Equipment Plant Operation & Maintenance	0	0	0		0	O	3.00
4.00	Transportation	0	0	0		0 0	0	4.00
5.00	Administrative and General	363, 335	0	0		0 0	363, 335	5.00
6.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	449, 927	0	0		0 0	449, 927	6.00
7.00	Physical Therapy	0	0	0		0 0	0	7.00
8.00 9.00	Occupational Therapy Speech Pathology	0	0	0		0 0 0 0	0	8.00 9.00
9.00	Medical Social Services	1, 829	0	0		0 0	1, 829	
11.00	Home Health Aide	130, 584	0	0		0 0	130, 584	
12.00	Supplies (see instructions)	0	0	0		0 0	0	
13.00 14.00	Drugs DME	0	0	0 0		0 0	0	
	HHA NONREIMBURSABLE SERVICES				1		~	
15.00	Home Dialysis Aide Services	0	0	0		0 0	0	
16.00 17.00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0	0	
18.00	Clinic	0	0	0		0 0	0	
19.00	Health Promotion Activities	0	0	0		0 0	0	
20.00 21.00	Day Care Program Home Delivered Meals Program	0	0	0		0 0	0	
22.00	Homemaker Service	0	0	0		0 0	0	
	All Others (specify)	8, 054	0	0		0 0	8, 054	
24.00	Total (sum of lines 1-23)	953,729 Administrative	0 Total (cols	0		0 0	953, 729	24.00
		& General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5.00	6.00					
1.00	Capital Related - Bldg. &							1.00
	Fixtures							
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 HHA REIMBURSABLE SERVICES	363, 335						5.00
6.00	Skilled Nursing Care	276, 889	726, 816					6.00
7.00	Physical Therapy	0	0					7.00
8.00 9.00	Occupational Therapy Speech Pathology	0						8.00 9.00
10.00	Medical Social Services	1, 126	2, 955					10.00
11.00	Home Heal th Aide	80, 363	210, 947					11.00
12.00 13.00	Supplies (see instructions) Drugs	0	0					12.00
14.00	DME	0	0					14.00
15 00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services							1 1 5 00
15.00 16.00	Respiratory Therapy	0	0					15.00
17.00	Private Duty Nursing	0	Ő					17.00
18.00	Clinic	0	О					18.00
19.00	Health Promotion Activities	0	0					19.00
	Day Care Program	0	0					20.00
20.00	Home Delivered Meals Program							21 00
20.00	Home Delivered Meals Program Homemaker Service	0 0	0 0					21.00 22.00
20. 00 21. 00 22. 00 23. 00		0 0 4, 957	0 0 13, 011 953, 729					

Heal th	Financial Systems		JASPER COUNT	Y HOSPI TAL	In Lieu of Form CMS-2552-1			
COST A	LLOCATION - HHA STATISTICAL BAS	SI S		Provi der HHA CCN:	CCN: 151324 157149	Period: From 01/01/2015 To 08/31/2015	Worksheet H-1 Part II Date/Time Pre 8/15/2016 3:5	pared:
						Home Health Agency I	PPS	
		Capital Rel	ated Costs					
		· · · · · ·	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	(MILEAGE)	onReconciliation	& General (ACCUM. COST)	
				3.00	4.00	5A. 00	5.00	
	GENERAL SERVICE COST CENTERS							1 1 00
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
	Transportation (see	0	0	0		0		4.00
I	instructions)							
	Administrative and General	0	0	0		0 -363,335	590, 394	5.00
	HHA REI MBURSABLE SERVI CES						440.007	1 / 00
	Skilled Nursing Care	0	5	0		0 0	449, 927	
	Physical Therapy Occupational Therapy	0	0	0		0 0	0	8.00
	Speech Pathol ogy		0	0		0 0	0	
	Medical Social Services		0	0		0 0	1,829	
	Home Heal th Aide	0	0	0		0 0	130, 584	•
	Supplies (see instructions)	0	0	0		0 0	00,001	•
	Drugs	0	0	0		0	0	13.00
	DME	0	0	0		0 0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
	Home Dialysis Aide Services	0	0	0		0 0	0	
	Respiratory Therapy	0	0	0		0 0	0	1 101 00
	Private Duty Nursing	0	0	0		0 0	0	
	Clinic Health Promotion Activities	0	0	0		0 0	0	
	Day Care Program	0	0	0		0 0	0	
	Home Delivered Meals Program		0	0			0	
	Homemaker Service	0	0	0		0 0	0	
	All Others (specify)	0	0	0		0 0	8,054	
	Total (sum of lines 1-23)	0	0	0		0 -363, 335	590, 394	
	Cost To Be Allocated (per	0	0	0		0	363, 335	
ľ	Worksheet H-1, Part I)							
0 / 00 <sup>1</sup>	Unit Cost Multiplier	0.000000	0. 000000	0.00000	0.0000	00	0. 615411	1 26 00

LUCATION OF GENERAL SERVIC	E COSTS TO	) HHA COST CEN	TERS	Provi der		Period:	Worksheet H-2	
				HHA CCN:		From 01/01/2015 To 08/31/2015	Part I Date/Time Pre 8/15/2016 3:5	pare 6 pr
						Home Health Agency I	PPS	
			CAPI TAL RELATED COSTS					
Cost Center Desc	cription	HHA Trial Balance (1)	NEW BLDG & FLXT	EMPLOYEE BENEFITS	Subtotal	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	
		0	1.00	DEPARTMENT 4.00	4A	5.00	7.00	
00 Administrative and Ge	neral	0	51, 245	230, 959	282, 204		29, 801	1
00 Skilled Nursing Care 00 Physical Therapy		726, 816 0	0	0	726, 816	5 143, 751	0	2
00 Occupational Therapy		0	0	0			0	
00 Speech Pathology		0	0	0	(	0 0	0	5
00 Medical Social Servic	es	2,955	0	0	2, 955		0	
00 Home Health Aide 00 Supplies (see instruc	tions)	210, 947 0	0	0	210, 947	7 41, 722	0	7
00 Drugs		0	0	0	(	0 0	0	9
OO DME		0	0	0	(	0 0	0	10
00 Home Dialysis Aide Se 00 Respiratory Therapy	rvi ces	0	0	0			0	
00 Private Duty Nursing		0	0	0			0	
00 Clinic		0	0	0	(	0	0	
00 Health Promotion Acti	vities	0	0	0	(	0	0	
00 Day Care Program 00 Home Delivered Meals	Drogram	0	0	0	(		0	
00 Homemaker Service	FT Ogt alli	0	0	0	(		0	
00 All Others (specify)		13, 011	0	0	13, 011	2, 573	0	
00 Total (sum of lines 1		953, 729	51, 245	230, 959			29, 801	
.00 Unit Cost Multiplier: 26, line 1 divided by					0.00000			21
of column 26, line 20								
column 26, line 1, ro	unded to							
6 decimal places. Cost Center Desc	rintion	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
COST Center Desc		LINEN SERVICE	HOUSEREEFING	DILIARI		ADMI NI STRATI ON	SERVICES &	
	-	0.00	0.00	10.00	11.00	12.00	SUPPLY	
00 Administrative and Ge	neral	8.00	9.00 26,508	10.00	11.00	13.00	14.00	1
0 Skilled Nursing Care		0	0	0	(	0 0	0	2
0 Physical Therapy		0	0	0	(	0 0	0	3
0 Occupational Therapy		0	0	0			0	4
		0	U	0		0	0	6
	es	0	0	0		0 0		7
00 Medical Social Servic	es	0	0	0 0	(		0	
00 Medical Social Servic 10 Home Health Aide 10 Supplies (see instruc		0000	0 0 0	0 0 0	(	0 0 0 0 0 0	0	
00 Medical Social Servic 00 Home Health Aide 00 Supplies (see instruc 00 Drugs		000000000000000000000000000000000000000	0 0 0 0	0 0 0 0			0	9
0 Medical Social Servic 0 Home Health Aide 0 Supplies (see instruc 0 Drugs 00 DME	ti ons)	0 0 0 0 0 0	0 0 0 0 0	0 0 0 0 0 0			0 0 0	9 10
00 Medical Social Servic 10 Home Health Aide 10 Supplies (see instruc 10 Drugs 10 DME 10 Home Dialysis Aide Se	ti ons)	0 0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0			0	9 10 11
<ul> <li>Medical Social Servic</li> <li>Home Health Aide</li> <li>Supplies (see instruction</li> <li>Drugs</li> <li>DME</li> <li>Home Dialysis Aide Se</li> <li>Respiratory Therapy</li> <li>Private Duty Nursing</li> </ul>	ti ons)	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0		0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0           0         0	0 0 0 0 0 0	9 10 11 12 13
<ul> <li>Medical Social Servic</li> <li>Home Health Aide</li> <li>Supplies (see instruc</li> <li>Drugs</li> <li>DME</li> <li>Home Dialysis Aide Se</li> <li>Respiratory Therapy</li> <li>Private Duty Nursing</li> <li>Clinic</li> </ul>	ti ons) rvi ces						0 0 0 0 0 0 0 0 0	9 10 11 12 13 14
<ul> <li>Medical Social Servic</li> <li>Home Health Aide</li> <li>Supplies (see instruc</li> <li>Drugs</li> <li>DME</li> <li>Home Dialysis Aide Se</li> <li>Respiratory Therapy</li> <li>Private Duty Nursing</li> <li>Clinic</li> <li>Health Promotion Acti</li> </ul>	ti ons) rvi ces						0 0 0 0 0 0 0 0 0 0 0 0	10 11 12 13 14 15
<ul> <li>Medical Social Servic</li> <li>Home Health Aide</li> <li>Supplies (see instruction</li> <li>Drugs</li> <li>DME</li> <li>Home Dialysis Aide Se</li> <li>Respiratory Therapy</li> <li>Private Duty Nursing</li> <li>Clinic</li> <li>Health Promotion Acti</li> <li>Day Care Program</li> </ul>	ti ons) rvi ces vi ti es		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0	9 10 11 12 13 14 15 16
<ul> <li>Medical Social Servic</li> <li>Home Health Aide</li> <li>Supplies (see instruc</li> <li>Drugs</li> <li>DME</li> <li>Home Dialysis Aide Se</li> <li>Respiratory Therapy</li> <li>Private Duty Nursing</li> <li>Clinic</li> <li>Health Promotion Acti</li> <li>Day Care Program</li> <li>Home Delivered Meals</li> <li>Homemaker Service</li> </ul>	ti ons) rvi ces vi ti es		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9 10 11 12 13 14 15 16 17 18
<ul> <li>Medical Social Servic</li> <li>Home Health Aide</li> <li>Supplies (see instruc</li> <li>Drugs</li> <li>DHe Dialysis Aide Se</li> <li>Home Dialysis Aide Se</li> <li>Respiratory Therapy</li> <li>Private Duty Nursing</li> <li>Clinic</li> <li>Health Promotion Acti</li> <li>Day Care Program</li> <li>Home Delivered Meals</li> <li>Homemaker Service</li> <li>All Others (specify)</li> </ul>	tions) rvices vities Program						0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9 10 11 12 13 14 15 16 17 18 19
Nedical Social Servic00Home Health Aide00Supplies (see instruct00Drugs00DME00Home Dialysis Aide Se00Respiratory Therapy00Private Duty Nursing00Clinic00Health Promotion Acti00Day Care Program00Home Delivered Meals00All Others (specify)00Total (sum of lines 1	tions) rvices vities Program -19) (2)		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 26, 508				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9 10 11 12 13 14 15 16 17 18 19 20
Nedical Social Servic00Home Health Aide00Supplies (see instruct00Drugs00DME00Home Dialysis Aide Se00Respiratory Therapy00Private Duty Nursing00Clinic00Health Promotion Acti00Day Care Program00Home Delivered Meals00All Others (specify)00Total (sum of lines 1	tions) rvices vities Program -19) (2) column		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 26, 508				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9 10 11 12 13 14 15 16 17 18 19
00Medical Social Servic00Home Health Aide00Supplies (see instruct00Drugs.00DME.00Home Dialysis Aide Se.00Respiratory Therapy.00Private Duty Nursing.00Clinic.00Health Promotion Acti.00Day Care Program.00Homemaker Service.00All Others (specify).00Total (sum of lines 1.00Unit Cost Multiplier:	tions) rvices vities Program -19) (2) column the sum minus		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 26, 508				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9 10 11 12 13 14 15 16 17 18 19 20

(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.

ealth Financial Systems ALLOCATION OF GENERAL SERVICE COSTS T	O HHA COST CENT	TERS	Provi der	CCN: 151324	Period:	Worksheet H-2	
			HHA CCN:	157149	From 01/01/2015 To 08/31/2015	Part I Date/Time Pre 8/15/2016 3:5	pared: 6 pm
					Home Health Agency I	PPS	
Cost Center Description	PHARMACY	MEDI CAL S RECORDS & LI BRARY	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
	15.00	16.00	17.00	24.00	25.00	26.00	
<ul> <li>Administrative and General</li> <li>Administrative and General</li> <li>Skilled Nursing Care</li> <li>Physical Therapy</li> <li>Occupational Therapy</li> <li>Speech Pathology</li> <li>Medical Social Services</li> <li>Home Health Aide</li> <li>Supplies (see instructions)</li> <li>Do Drugs</li> <li>O DME</li> <li>Home Dialysis Aide Services</li> <li>O Home Dialysis Aide Services</li> <li>O Respiratory Therapy</li> <li>O Clinic</li> <li>O Bay Care Program</li> <li>O Home Delivered Meals Program</li> <li>O Home Delivered Meals Program</li> <li>O Home Service</li> <li>O All Others (specify)</li> <li>O Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to 6 decimal places.</li> </ul>				394, 32 870, 56 252, 66 1, 536, 68	57       0         0       0         0       0         0       0         39       0         59       0         0       0	394, 328 870, 567 0 0 3, 539 252, 669 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 13.0 14.0 15.0 14.0 15.0 17.0 18.0 17.0
Cost Center Description	Allocated HHA A&G (see Part II)	Total HHA Costs					
	27.00	28.00					
<ul> <li>Administrative and General</li> <li>Administrative and General</li> <li>Skilled Nursing Care</li> <li>Physical Therapy</li> <li>Occupational Therapy</li> <li>Sconspect Pathology</li> <li>Medical Social Services</li> <li>Home Health Aide</li> <li>Supplies (see instructions)</li> <li>Drugs</li> <li>O Drugs</li> <li>O ME</li> <li>Meme Dialysis Aide Services</li> <li>Meme Therapy</li> <li>O Respiratory Therapy</li> <li>O Clinic</li> <li>O Hard Program</li> <li>Home Delivered Meals Program</li> <li>Mome Total (sum of lines 1-19) (2)</li> <li>O Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to</li> </ul>	300, 509 0 0 1, 222 87, 218 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 171, 076 0 0 4, 761 339, 887 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					$\begin{array}{c} 1. \ 0\\ 2. \ 0\\ 3. \ 0\\ 4. \ 0\\ 5. \ 0\\ 6. \ 0\\ 7. \ 0\\ 8. \ 0\\ 9. \ 0\\ 10. \ 0\\ 11. \ 0\\ 12. \ 0\\ 13. \ 0\\ 14. \ 0\\ 15. \ 0\\ 15. \ 0\\ 15. \ 0\\ 16. \ 0\\ 17. \ 0\\ 18. \ 0\\ 19. \ 0\\ 20. \ 0\\ 21. \ 0\\ \end{array}$

(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.

Health Fina	ancial Systems		JASPER COUNT	Y HOS	PI TAL			In Lie	u of Form CMS-2	2552-10
ALLOCATI ON BASI S	OF GENERAL SERVICE COSTS T	O HHA COST CENT	TERS STATISTIC		Provider HHA CCN:	CCN: 151324 157149	F	eriod: rom 01/01/2015 o 08/31/2015	Worksheet H-2 Part II Date/Time Pre 8/15/2016 3:5	
								Home Health	PPS	
		CAPI TAL						Agency I		
	Cost Center Description	RELATED COSTS NEW BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Recon	ciliation	ADMI NI STRAT & GENERAL (ACCUM. COST)		OPERATI ON OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (DOLLAR VALUE)	
1.00		1.00	4.00		5A	5.00		7.00	8.00	1.00
2.00 Skil 3.00 Phys 4.00 Occt 5.00 Spec 6.00 Medi 7.00 Home 8.00 Supp 9.00 Drug 10.00 DME 11.00 Home 12.00 Resp 13.00 Priv 14.00 Clir 15.00 Heal 16.00 Day 17.00 Home 18.00 Home 19.00 All 20.00 Tota 21.00 Tota	e Dialysis Aide Services Diratory Therapy Vate Duty Nursing	3, 086 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	831, 313 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	CAF	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	726, s 2, 210,	816 0 9955 947 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ \end{array}$
		SERVI CE)	SERVED)	Н	OURS)	(MAN HOURS)		SUPPLY (100% ALLOCATI ON)	ALLOCATI ON)	
1.00		9.00	10.00	-	11.00	13.00	-	14.00	15.00	1.00
2.00 Skil 3.00 Phys 4.00 Occt 5.00 Spec 6.00 Medi 7.00 Home 8.00 Supp 9.00 Drug 10.00 DME 11.00 Home 12.00 Resp 13.00 Priv 14.00 Clir 15.00 Heal 16.00 Day 17.00 Home 18.00 Home 19.00 Tota 21.00 Tota	e Dialysis Aide Services Diratory Therapy Vate Duty Nursing	5, 340 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00

Heal th	Financial Systems		JASPER COUNTY H	OSPI TAL		In Lie	u of Form CMS-	2552-10
	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS STATI STI CAL	Provi der	CCN: 151324	Peri od:	Worksheet H-2	
BASI S				HHA CCN:	157149	From 01/01/2015 To 08/31/2015		nared
				THIA CON.	137147	10 00/31/2013	8/15/2016 3:5	
						Home Health	PPS	
		1000				Agency I		
	Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE					
		LIBRARY	(TIME					
		(TIME	SPENT)					
		SPENT)						
		16.00	17.00					
1.00	Administrative and General	C C	0					1.00
2.00	Skilled Nursing Care	C	0					2.00
3.00	Physical Therapy	C	0					3.00
4.00	Occupational Therapy		0					4.00
5.00	Speech Pathol ogy		0					5.00
6.00 7.00	Medical Social Services Home Health Aide		0					6.00 7.00
7.00 8.00	Supplies (see instructions)		0					8.00
9.00	Drugs							9.00
10.00	DME		0					10.00
11.00	Home Dialysis Aide Services		0					11.00
12.00	Respiratory Therapy	l c	0					12.00
13.00	Private Duty Nursing	c c	0					13.00
14.00	Clinic	c c	0					14.00
15.00	Health Promotion Activities	C	0					15.00
16.00	Day Care Program	C	0					16.00
	Home Delivered Meals Program	C	0					17.00
	Homemaker Service	C	0					18.00
	All Others (specify)		0					19.00
20.00	Total (sum of lines 1-19)		0					20.00
21.00	Total cost to be allocated							21.00
22.00	Unit cost multiplier	0. 000000	0. 000000					22.00

Heal th	n Financial Systems		JASPER COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	TIONMENT OF PATIENT SERVICE COST	ſS			CCN: 151324	Peri od:	Worksheet H-3	
				HHA CCN:	157149	From 01/01/2015 To 08/31/2015		
				Titl	e XVIII	Home Health	PPS	
	Cost Center Description	From, Wkst.	Facility Costs	Shared	Total HHA	Agency I Total Visits	Average Cost	
		H-2, Part I,	(from Wkst.	Ancillary	Costs (col s.		Per Visit	
		col. 28, line	H-2, Part I)	Costs (from	+ 2)		(col. 3 ÷ col.	
			1.00	Part II)	2.00	4.00	4)	
	PART I - COMPUTATION OF LESSER		1.00				5.00	
	BENEFICIARY COST LIMITATION	OF AGOREGATE I		CORECATE OF T		ITATION COST, O	K	
	Cost Per Visit Computation	i	1	1	1		1	
1.00	Skilled Nursing Care	2.00			1, 171, 0			1.00
2.00	Physical Therapy	3.00						•
3.00	Occupational Therapy	4.00						•
4.00 5.00	Speech Pathology Medical Social Services	5.00		61, 684	4, 7			•
6.00	Home Heal th Ai de	7.00			339, 8			
7.00	Total (sum of lines 1-6)	1.00	1, 515, 724					7.00
			110101121	100,010	Program Visi			1100
					P	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject Deductibles Coinsurance	& Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation		1		*			
8.00	Skilled Nursing Care		23844	C	., -			8.00
8.01	Skilled Nursing Care		50031	C		06		8. 01
9.00	Physical Therapy		23844	0		56		9.00
9.01	Physical Therapy		50031 23844			57		9.01
10. 00 10. 01	1 13		23844 50031		3	39 0		10.00 10.01
11.00			23844		1	45		11.00
11.00			50031			0		11.00
12.00			23844			22		12.00
12.01			50031			1		12.01
13.00	Home Health Aide		23844	0	1,8	33		13.00
13.01	Home Health Aide		50031	C	1	11		13.01
14.00	Total (sum of lines 8-13)			0	5, 9			14.00
	Cost Center Description	From Wkst. H-2			Total HHA	Total Charges		
		Part I, col.	(from Wkst.	Ancillary	Costs (col s.		÷ col. 4)	
		28, line	H-2, Part I)	Costs (from Part II)	+ 2)	Records)		
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Comput		1.00	2.00	0.00	1.00	0.00	
15.00		8.00	0	C	D	0 0	0. 000000	15.00
16.00	Cost of Drugs	9.00	0	0		0 0	0. 000000	16.00
			Program Visits		Cost of			
					Servi ces			
	Cast Castar Description	Davet A		t B		Part B	Cubi ast to	
	Cost Center Description	Part A	Not Subject to Deductibles &		Part A	Not Subject to Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION							
1 00	Cost Per Visit Computation		0.004	1	T	0 701 070		1 00
1.00	Skilled Nursing Care Physical Therapy	0				0 701, 379		1.00
2.00 3.00	Occupational Therapy					0 150, 928 0 116, 748		2.00 3.00
3.00 4.00	Speech Pathol ogy					0 52, 306		4.00
4.00 5.00	Medi cal Soci al Servi ces					0 52, 300		4.00 5.00
6.00	Home Heal th Ai de	0				0 128, 576		6.00
7.00	Total (sum of lines 1-6)	0			1	0 1, 153, 993		7.00
							1	

APPURT	IONMENT OF PATIENT SERVICE COST	S		Provi der HHA CCN:	CCN: 151324 157149	Period: From 01/01/2015 To 08/31/2015	Worksheet H-3 Part I Date/Time Pre	pared:
					e XVIII	Home Health	8/15/2016 3:5 PPS	6 pm
						Agency I	FFS	
	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation	1						
3. 00 3. 01 9. 00 9. 01 0. 00 0. 01 1. 00 1. 01 2. 00 2. 01	Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services							8. ( 8. ( 9. ( 10. ( 10. ( 11. ( 11. ( 12. ( 12. (
3.00	Home Health Aide							13.0
3.01	Home Health Aide Total (sum of lines 8-13)							13.0
4.00	Total (sum of Times 8-13)	Program Covered Cha		irges	Cost of Services			14.0
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance	Subject to	Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	<u> </u>
	Supplies and Drugs Cost Computa				1			
5.00 6.00	Cost of Medical Supplies Cost of Drugs	0	0	0		0 0	C	
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LI	MITATION COST, OR		
	Cost Per Visit Computation	-						
. 00	Skilled Nursing Care	701, 379						1.0
. 00 . 00	Physical Therapy Occupational Therapy	150, 928 116, 748						2.0
. 00	Speech Pathol ogy	52, 306						4. (
. 00	Medical Social Services	4, 056						5.0
. 00	Home Health Aide	128, 576						6.0
. 00	Total (sum of lines 1-6) Cost Center Description	1, 153, 993			-			7.0
	cost center bescription	12.00	-			·		1
	Limitation Cost Computation		1					
	Skilled Nursing Care							8.0
	Skilled Nursing Care							8.
. 01	Physical Therapy Physical Therapy							9. 9.
. 01 . 00								10.
. 01 . 00 . 01	Occupational Therapy							10.
. 01 . 00 . 01 0. 00 0. 01	Occupational Therapy Occupational Therapy							
. 01 . 00 . 01 0. 00 0. 01 1. 00	Occupational Therapy Occupational Therapy Speech Pathology							11.
. 01 . 00 . 01 0. 00 0. 01 1. 00 1. 01	Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology							11.
. 01 . 00 . 01 0. 00 0. 01 1. 00 1. 01 2. 00	Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services							11. 12.
3. 00 3. 01 9. 00 9. 01 10. 00 10. 01 11. 00 11. 01 12. 00 12. 01 13. 00	Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology							11. 11. 12. 12. 13.
. 01 . 00 . 01 0. 00 0. 01 1. 00 1. 01 2. 00 2. 01	Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services Medical Social Services Home Health Aide Home Health Aide							11. 12. 12.

Heal th	n Financial Systems		JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPOR	TIONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 151324	Peri od:	Worksheet H-3	
				HHA CCN:	157149	From 01/01/2015 To 08/31/2015		pared: 6 pm
				Ti tl	e XVIII	Home Health	PPS	
						Agency I		
	Cost Center Description		Cost to Charge		HHA Shared			
		Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
		9, line		provi der	Costs (col.	1 Indicated		
				records)	x col. 2)			
	0 1.00			2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS		
1.00	Physical Therapy	66.00	0. 820121	290, 592	238, 3	21 col. 2, line 2	. 00	1.00
1.01	Physical Therapy 1	66. 01	1. 165019	0		0 col. 2, line 2	. 01	1.01
2.00	Occupational Therapy	67.00	2. 391562	69, 552	166, 3	38 col. 2, line 3	. 00	2.00
2.01	Occupational Therapy 1	67.01	1.870539	0		Ocol. 2, line 3	. 01	2.01
3.00	Speech Pathology	68.00	2. 327244	26, 505	61, 6	84 col. 2, line 4	. 00	3.00
3.01	Speech Pathology 1	68.01	2. 129563	0		0 col. 2, line 4	. 01	3. 01
4.00	Cost of Medical Supplies	71.00	0. 407060	0		0 col. 2, line 1	5.00	4.00
5.00	Cost of Drugs	73.00	0. 421787	0		0 col. 2, line 1	6. 00	5.00

<b>LCOL</b>	Financial Systems JASPER COUNTY HOS ATION OF HHA REIMBURSEMENT SETTLEMENT		CCN: 151324	Peri od:	worksheet H-4	
		HHA CCN:	157149	From 01/01/2015 To 08/31/2015		
		Ti tl	e XVIII	Home Health Agency I	PPS	
					t B	
			Part A		Deductibles &	
			1.00	Coi nsurance 2.00	Coi nsurance 3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMA	RY CHARGE		2.00	3.00	-
	Reasonable Cost of Part A & Part B Services		.0			1
00	Reasonable cost of services (see instructions)			0 0		1
00	Total charges			0 0	0	2
	Customary Charges		1			
00	Amount actually collected from patients liable for payment for s on a charge basis (from your records)	ervi ces		0 0	0	3
00	Amount that would have been realized from patients liable for pa	vment		0 0	0	4
	for services on a charge basis had such payment been made in acc			0	, i i i i i i i i i i i i i i i i i i i	·
	with 42 CFR §413.13(b)					
00	Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000			
00	Total customary charges (see instructions)			0 0	0	
00	Excess of total customary charges over total reasonable cost (co only if line 6 exceeds line 1)	mprete		0 0	0	7
00	Excess of reasonable cost over customary charges (complete only	ifline		0 0	0	6
-	1 exceeds line 6)			-	_	
00	Primary payer amounts			0 0	-	9
				Part A Services	Part B Services	
				1.00	2.00	
~ ~	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
00	Total reasonable cost (see instructions)			0		
00 00	Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers			0	624, 196 53, 938	
00	Total PPS Reimbursement - LUPA Episodes			0	11, 162	
00	Total PPS Reimbursement - PEP Episodes			0	6, 085	
00	Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	41, 038	15
00	Total PPS Outlier Reimbursement - PEP Episodes			0	3, 402	10
00	Total Other Payments			0	0	
00	DME Payments			0	0	
	Oxygen Payments Prosthetic and Orthotic Payments			0	0	
	Part B deductibles billed to Medicare patients (exclude coinsura	nce)		0	0	
00		1100)		0	-	
00 00						
00 00 00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8)			0	0	1 23
00 00 00 00	Subtotal (sum of lines 10 thru 20 minus line 21)			-		
00 00 00 00 00 00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records)			0	739, 821 0	24 25
00 00 00 00 00 00 00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25)			0	739, 821 0	24 25 26
00 00 00 00 00 00 00 00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records)			0	739, 821 0	24 25 26 27
00 00 00 00 00 00 00 00 00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst	ructions)		000000000000000000000000000000000000000	739, 821 0 739, 821	24 25 26 27 28
00 00 00 00 00 00 00 00 00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2	ructions)		0	739, 821 0 739, 821 739, 821	24 25 26 27 28 29
00 00 00 00 00 00 00 00 00 00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst	ructions)		000000000000000000000000000000000000000	739, 821 0 739, 821 739, 821 -3, 010	24 25 26 27 28 29 30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS	ructions)			739, 821 0 739, 821 739, 821 -3, 010 0	24 25 26 27 28 29 30 30
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions)	ructions)			739, 821 0 739, 821 -3, 010 0 736, 811 14, 736	24 25 26 27 28 29 30 30 30 31 31
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	ructions)			739, 821 0 739, 821 -3, 010 0 736, 811 14, 736 722, 075	24 25 26 27 28 29 30 30 31 31 31
. 00         . 00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions) Tentative settlement (for contractor use only)	ructions) 7)			739, 821 0 739, 821 -3, 010 0 736, 811 14, 736 722, 075 0	24 25 26 27 28 29 30 30 30 31 31 31 32 33
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see inst Total costs - current cost reporting period (line 26 plus line 2 OTHER ADJUSTMENTS Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)	ructions) 7) 33)			739, 821 0 739, 821 -3, 010 0 736, 811 14, 736 722, 075 0 0	24 25 26 27 28 29 30 30 31 31 31 32 33 34

	SIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED	T0	Provi der	CCN: 151324		eriod: rom 01/01/2015	Worksheet H-5	
0010	IN DENETTGANTES		HHA CCN:	157149	To		Date/Time Prep 8/15/2016 3:56	bare 5 pm
						Home Health Agency I	PPS	-
			I npati en	t Part A		Par	t B	
			′dd/yyyy	Amount		mm/dd/yyyy	Amount	
			1.00	2.00		3.00	4.00	
00 00	Total interim payments paid to provider 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		722, 075 0	1. 2.
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.
	Program to Provider			1		1		
01					0		0	3.
02 03					0 0		0	3
03					0		0	3
05					0		0	3
	Provider to Program				-	1		
50					0		0	3
51					0		0	3
52					0		0	3
53					0		0	3
54					0		0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0		0	3
~~	3. 50-3. 98)				~		700 075	
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		722, 075	4
	TO BE COMPLETED BY CONTRACTOR							
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
	Program to Provider					I		
D1					0		0	5
)2					0		0	5
)3					0		0	5
	Provider to Program			I				
50					0		0	5
51 52					0		0	5
o∠ 79	Subtotal (sum of lines 5.01–5.49 minus sum of lines				0		0	5
)0	5. 50-5. 98) Determined net settlement amount (balance due) based on				U		0	6
-	the cost report. (1)							
01	SETTLEMENT TO PROVIDER				0		0	6
02	SETTLEMENT TO PROGRAM				0		0	6
00	Total Medicare program liability (see instructions)	_			0		722, 075	7
						Contractor	NPR Date	
				)		Number	(Mo/Day/Yr)	
00	Name of Contractor		(	)		1.00	2.00	8

Heal th	Financial Systems	JASPER COUNTY	' HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 151324	Peri od:	Worksheet K	
			Hochi co. (	CN: 151519	From 01/01/2015 To 08/31/2015	Date/Time Pre	narod
			nospi ce c	CN. 101019	10 06/31/2015	8/15/2016 3:5	
					Hospi ce I		
		Salaries (from	Empl oyee	Transportatio	on Contracted	Other	
		Wkst. K-1) E	Benefits (from	(see inst.)	Services (from		
			Wkst. K-2)		Wkst. K-3)		
		1.00	2.00	3.00	4.00	5.00	
1 00	GENERAL SERVICE COST CENTERS					0	1 1 00
1.00	Capital Related Costs-Bldg and Fixt.				0	0	
2.00	Capital Related Costs-Movable Equip.		0		0	0	
3.00	Plant Operation and Maintenance	0	0		0 0	0	
4.00	Transportation - Staff	0	0		0 0	0	
5.00	Volunteer Service Coordination	0	0		0 0	0	
6.00	Administrative and General	40, 898	0		0 0	167, 741	6.00
7 00	INPATIENT CARE SERVICE		0	1	0	0	7 00
7.00	Inpatient - General Care	0	0		0 0		
8.00	Inpatient - Respite Care	0	0		0 0	0	8.00
0.00	VI SI TI NG SERVI CES	0	0	1	0 0	0	0.00
9.00	Physician Services	25, 376	0		0 0 0 0	0	•
10.00	Nursing Care		0		0 0		
11.00	Nursing Care-Continuous Home Care	0	0		-	0	
12.00	Physical Therapy	-	0		0 0		
13.00	Occupational Therapy	0	0		-	0	
14. 00 15. 00	Speech/ Language Pathology Medical Social Services	34, 745	0		0 0	0	•
	Spiritual Counseling	34, 745	0		0 0	0	
16. 00 17. 00	Dietary Counseling	0	0		0 0	0	
18.00	Counseling - Other	0	0		0 0	0	
18.00	Home Health Aide and Homemaker	2,665	0		0 0	0	
20.00	HH Aide & Homemaker - Cont. Home Care	2,005	0		0 0	0	
20.00	Other	0	0		0 0	0	
21.00	OTHER HOSPICE SERVICE COSTS	<u>ч</u>	0		0 0	0	21.00
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22.00
23.00	Anal gesi cs	0	0		0 0	0	
24.00	Sedatives / Hypnotics	0	0		0 0	0	
25.00	Other - Specify	0	0		0 0	0	
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	
27.00	Pati ent Transportati on	0	0		0 0	0	
28.00	Imaging Services	0	0		0 0	0	
29.00	Labs and Diagnostics	0	0		0 0	0	
30.00	Medical Supplies	0	0		0 0	0	
31.00	Outpatient Services (including E/R Dept.)	o	0		0 0	0	
32.00	Radiation Therapy	0	0		0 0	0	32.00
33.00	Chemotherapy	0	0		0 0	0	33.00
34.00	Other	0	0		0 0	0	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE						1
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0	0	36.00
37.00	Fundrai si ng	0	0		0 0	0	37.00
38.00	Other Program Costs	0	0		0 0	0	38.00
39.00	Total (sum of lines 1 thru 38)	103, 684	0		0 0	167, 741	39.00

ANALYSIS OF PROVIDER-BASED HOSPICE COSTS         Provider         CXR: 151324         Provider         Kitsis           Hospice COX:         151374         Provider         CXR: 151374         Provider         Provider         CXR: 151374         P	Heal th	Financial Systems	JASPER COUNT	Y HOSPITA	AL.			In Lie	u of Form CMS-2	2552-10
Hospice COK:         191 10         08/31/2015         Date/Time Prepared: 1/5/2016 3/56 pm           Interview         Total (col s. 1-5)         Recl assi fi cati 1-5)         Statutotal (col s. 1-6)         Hospice 1           1         0         6 + col. 7)         6 + col. 7)         9 + col. 9)         10.00           1         0	ANALYS	IS OF PROVIDER-BASED HOSPICE COSTS		Pro	vi der	CCN: 151324	Pe	ri od:	Worksheet K	
Cell         Total (col: son of 6 (col: 7). 1-5)         Reclassificati Subtral (col: 6)         Adjustments         Total (col: 8)           Central Related Costs-Bidg and Fixt.         0 <t< td=""><td></td><td></td><td></td><td>Hos</td><td>pice (</td><td>CCN: 151519</td><td></td><td></td><td></td><td></td></t<>				Hos	pice (	CCN: 151519				
								Hospi ce I	0/10/2010 0.0	
1-5)         on         6 col.         7)         ± col.         9)           Central SERVICE COST CENTERS			Total (cols.	Recl assi t	fi cati	Subtotal (co			Total (col. 8	
CENERAL SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           1.00         Capital Related Costs-Bidg and Fixt.         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>.,</td> <td></td> <td></td>								.,		
1.00       Capital Related Costs-Budg and Fixt.       0 <td></td> <td></td> <td></td> <td></td> <td>)</td> <td></td> <td></td> <td>9.00</td> <td></td> <td></td>					)			9.00		
2.00         Capital Related Costs-Movable Equip.         0		GENERAL SERVICE COST CENTERS		•					·	
3.00         Plant Operation and Maintenance         0	1.00	Capital Related Costs-Bldg and Fixt.	0		0		0	0	0	1.00
4.00         Transportation - Staff         0         0         0         0         0         0         0         0         0         0         5.00         0         1.00         1.00         208,639         0         208,639         0         208,639         0         208,639         0         208,639         0         208,639         0         208,639         0         208,639         0         208,639         0         208,639         0         208,639         0         208,639         0 <th< td=""><td>2.00</td><td>Capital Related Costs-Movable Equip.</td><td>0</td><td></td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>2.00</td></th<>	2.00	Capital Related Costs-Movable Equip.	0		0		0	0	0	2.00
5.00         Volunteer Service Coordination         0	3.00	Plant Operation and Maintenance	0		0		0	0	0	3.00
6.00         Administrative and General         208,639         0         208,639         0         208,639         6.00           INPATIENT CARE SERVICE	4.00	Transportation - Staff	0		0		0	0	0	4.00
INPATI ENT CARE SERVICE         Impatient - concertain care         0 <th< td=""><td>5.00</td><td>Volunteer Service Coordination</td><td>0</td><td></td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>5.00</td></th<>	5.00	Volunteer Service Coordination	0		0		0	0	0	5.00
7.00         Inpatient - General Care         0<	6.00	Administrative and General	208, 639		0	208, 6	39	0	208, 639	6.00
8.00         Inpatient - Respite Care         0<				•						
VISITING SERVICES         O <tho< th="">         O         O</tho<>	7.00	Inpatient - General Care	0		0		0	0	0	7.00
9.00         Physician Services         0	8.00	Inpatient - Respite Care	0		0		0	0	0	8.00
10.00         Nursing Care         25,376         0         25,376         0         25,376         0         11.00           11.00         Nursing Care continuous Home Care         0         0         0         0         11.00           12.00         Physical Therapy         0         0         0         0         12.00           13.00         Occupational Therapy         0         0         0         0         11.00           14.00         Speech/ Language Pathology         0         0         0         0         11.00           15.00         Medical Social Services         34,745         34,745         0         34,745         15.00           16.00         Spiritual Conseling         0         0         0         0         16.00           17.00         Dietary Courseling         0         0         0         0         17.00           18.00         Courseling - Other         0         0         0         0         22.00           10.00         Other         0         0         0         0         0         22.00           20.00         Progs, Biological and Infusion Therapy         0         0         0         22.00		VI SI TI NG SERVI CES								
11.00       Nursing Care-Continuous Home Care       0	9.00	Physi ci an Servi ces	0		0		0	0	0	9.00
12.00       Physical Therapy       0       0       0       0       12.00         13.00       Occupational Therapy       0       0       0       0       0       13.00         14.00       Speech/ Language Pathology       0       0       0       0       0       13.00         15.00       Medical Social Services       34,745       0       34,745       0       34,745       0       14.00         16.00       Spiritual Counseling       0       0       0       0       0       16.00         17.00       Dietary Counseling       0       0       0       0       17.00         18.00       Counseling - Other       0       0       0       0       18.00         19.00       Home Healt h Aide and Homemaker       2.665       0       2.665       0       2.665       2.665         10.00       Ther       0       0       0       0       20.00       18.00         20.00       Orugs, Biological and Infusion Therapy       0       0       0       0       21.00         0       O       0       0       0       0       0       22.00         21.00       Drugs, Biological and	10.00	Nursing Care	25, 376		0	25, 3	76	0	25, 376	10.00
13.00       Occupational Therapy       0       0       0       0       13.00         14.00       Speech/Language Pathol ogy       0       0       0       0       0       14.00         15.00       Medical Social Services       34.745       0       34.745       0       34.745       0       14.00         16.00       Spiritual Counseling       0       0       0       0       0       16.00         17.00       Dietary Counseling       0       0       0       0       0       16.00         18.00       Counseling - Other       0       0       0       0       0       17.00         19.00       Home Heal th Aide and Homemaker       2.665       0       2.665       0       2.665       19.00         20.00       Puther       0       0       0       0       0       21.00         21.00       Other       0       0       0       0       22.00       23.00         21.00       Dirtex Biological and Infusion Therapy       0       0       0       0       22.00         22.00       Patient Transportation       0       0       0       0       22.00         25.00 <td>11.00</td> <td>Nursing Care-Continuous Home Care</td> <td>0</td> <td></td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>11.00</td>	11.00	Nursing Care-Continuous Home Care	0		0		0	0	0	11.00
14.00       Speech/Language Pathology       0       0       0       0       14.00         15.00       Medical Social Services       34,745       0       34,745       0       34,745       15.00         16.00       Spiritual Counseling       0       0       0       0       0       16.00         17.00       Dietary Counseling       0       0       0       0       17.00         18.00       Counseling - Other       0       0       0       0       17.00         19.00       Home Heal th Aide and Homemaker       2,665       0       2,665       19.00         10.00       Other       0       0       0       0       0       20.00         21.00       Other       0       0       0       0       0       22.00         23.00       Anal gesics       0       0       0       0       22.00         24.00       Sedatives / Hypnotics       0       0       0       23.00         25.00       Other - Specify       0       0       0       24.00         26.00       Durable Medical Equipment/Oxygen       0       0       0       27.00         28.00       Inaging	12.00	Physical Therapy	0		0		0	0	0	12.00
14.00       Speech/Language Pathology       0       0       0       0       14.00         15.00       Medical Social Services       34,745       0       34,745       0       34,745       15.00         16.00       Spiritual Counseling       0       0       0       0       0       16.00         17.00       Dietary Counseling       0       0       0       0       17.00         18.00       Counseling - Other       0       0       0       0       17.00         19.00       Home Heal th Aide and Homemaker       2,665       0       2,665       19.00         10.00       Other       0       0       0       0       0       20.00         21.00       Other       0       0       0       0       0       22.00         23.00       Anal gesics       0       0       0       0       22.00         24.00       Sedatives / Hypnotics       0       0       0       23.00         25.00       Other - Specify       0       0       0       24.00         26.00       Durable Medical Equipment/Oxygen       0       0       0       27.00         28.00       Inaging	13.00	Occupational Therapy	0		0		0	0	0	13.00
15.00       Medical Social Services       34,745       0       34,745       0       34,745       0<	14.00		0		0		0	0	0	14.00
16.00       Spiritual Counseling       0       0       0       0       0       16.00         17.00       Dietary Counseling       0       0       0       0       17.00         18.00       Counseling       0       0       0       0       18.00         18.00       Counseling       0       0       0       0       18.00         19.00       Home Heal th Aide and Homemaker       2,665       0       2,665       0       2,665       19.00         20.00       Dther       0       0       0       0       0       0       20.00         0       Other       0       0       0       0       0       0       22.00         0       Other       0       0       0       0       0       22.00         20.00       Ortges, Biological and Infusion Therapy       0       0       0       0       22.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       24.00         25.00       Other - Specify       0       0       0       0       0       27.00         26.00       Durable Medical Equipment/Oxygen       0       0 <td>15.00</td> <td></td> <td>34, 745</td> <td></td> <td>0</td> <td>34, 7</td> <td>45</td> <td>0</td> <td>34, 745</td> <td>15.00</td>	15.00		34, 745		0	34, 7	45	0	34, 745	15.00
17.00       Dietary Counseling       0       0       0       0       0       0       0       0       17.00         18.00       Counseling - Other       0	16.00	Spiritual Counseling	0		0			0	0	16.00
18.00       Counseling - Other       0       0       0       0       0       0       18.00         19.00       Home Heal th Aide and Homemaker       2,665       0       2,665       0       2,665       19.00         20.00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       20.00         0       Other       0       0       0       0       0       20.00         0       Other       0       0       0       0       0       20.00         0       Drugs, Biol ogical and Infusion Therapy       0       0       0       0       22.00         20.00       Anal gesics       0       0       0       0       22.00         21.00       Sedatives / Hypnotics       0       0       0       24.00       25.00         24.00       Sedatives / Hypnotics       0       0       0       0       25.00         25.00       Durable Medical Equipment/Oxygen       0       0       0       27.00         28.00       Durable Medical Supplies       0       0       0       29.00         20.00       Labs and Diagnostics       0       0       0       0	17.00		0		0		0	0	0	17.00
19.00       Home Heal th Ai de and Homemaker       2, 665       0       2, 665       0       2, 665       19.00         20.00       HH Ai de & Homemaker - Cont. Home Care       0       <	18.00		0		0		0	0	0	18.00
21.00         Other         O	19.00		2,665		0	2,6	65	0	2,665	19.00
OTHER HOSPICE SERVICE COSTS           22.00         Drugs, Biological and Infusion Therapy         0         0         0         0         22.00           23.00         Anal gesics         0         0         0         0         0         22.00           24.00         Sedatives / Hypnotics         0         0         0         0         0         23.00           24.00         Sedatives / Hypnotics         0         0         0         0         24.00           25.00         Other - Specify         0         0         0         0         25.00           26.00         Durable Medical Equipment/Oxygen         0         0         0         0         26.00           27.00         Patient Transportation         0         0         0         0         27.00           28.00         Labs and Diagnostics         0         0         0         0         28.00           29.00         Labs and Diagnostics         0         0         0         0         29.00           30.00         Medical Supplies         0         0         0         0         30.00           31.00         Outpatient Services (including E/R Dept.)         0         0	20.00	HH Aide & Homemaker - Cont. Home Care	0		0		0	0	0	20.00
22.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       22.00         23.00       Analgesics       0       0       0       0       0       23.00         24.00       Sedatives / Hypnotics       0       0       0       0       0       23.00         24.00       Sedatives / Hypnotics       0       0       0       0       24.00         25.00       Other - Specify       0       0       0       0       24.00         26.00       Durable Medical Equipment/Oxygen       0       0       0       0       26.00         27.00       Patient Transportation       0       0       0       0       27.00         28.00       Imaging Services       0       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       0       28.00         30.00       Medical Supplies       0       0       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       31.00         32.00       Radiation Therapy       0       0       0	21.00	Other	0		0		0	0	0	21.00
23.00       Analgesics       0       0       0       0       23.00         24.00       Sedatives / Hypnotics       0       0       0       0       24.00         25.00       Other - Specify       0       0       0       0       25.00         26.00       Durable Medical Equipment/Oxygen       0       0       0       0       25.00         26.00       Patient Transportation       0       0       0       0       26.00         27.00       Patient Transportation       0       0       0       0       28.00         28.00       Imaging Services       0       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       0       29.00         30.00       Medical Supplies       0       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       30.00         32.00       Radiation Therapy       0       0       0       0       0       33.00         34.00       Other       0       0       0       0       0       0       0       34.00		OTHER HOSPICE SERVICE COSTS								
24.00       Sedatives / Hypnotics       0       0       0       0       24.00         25.00       Other - Specify       0       0       0       0       25.00         26.00       Durable Medical Equipment/Oxygen       0       0       0       0       26.00         27.00       Patient Transportation       0       0       0       0       27.00         28.00       Imaging Services       0       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       0       29.00         30.00       Medical Supplies       0       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       0       33.00       33.00         34.00       Other       0       0       0       0       0       0       34.00         Hyperiodical Supplice NonRELMBURSABLE SERVICE          0       0	22.00	Drugs, Biological and Infusion Therapy	0		0		0	0	0	22.00
25.00       Other - Specify       0       0       0       0       25.00         26.00       Durable Medical Equipment/Oxygen       0       0       0       0       26.00         27.00       Pati ent Transportation       0       0       0       0       27.00         28.00       Imagi ng Services       0       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       0       29.00         30.00       Medical Supplies       0       0       0       0       0       29.00         31.00       Outpati ent Services (including E/R Dept.)       0       0       0       0       30.00         32.00       Radiation Therapy       0       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       0       33.00         34.00       Other       0       0       0       0       0       33.00         34.00       Other       0       0       0       0       0       34.00         HOSPICE NONREI MBURSABLE SERVI CE         TO       0       0       0 <td< td=""><td>23.00</td><td>Anal gesi cs</td><td>0</td><td></td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>23.00</td></td<>	23.00	Anal gesi cs	0		0		0	0	0	23.00
26.00         Durable Medical Equipment/Oxygen         0         0         0         0         0         26.00           27.00         Patient Transportation         0         0         0         0         27.00           28.00         Imaging Services         0         0         0         0         28.00           29.00         Labs and Diagnostics         0         0         0         0         29.00           30.00         Medical Supplies         0         0         0         0         29.00           31.00         Outpatient Services (including E/R Dept.)         0         0         0         0         30.00           32.00         Radiation Therapy         0         0         0         0         31.00           32.00         Chemotherapy         0         0         0         0         32.00           33.00         Chemotherapy         0         0         0         0         33.00           44.00         Uther         0         0         0         0         34.00           HOSPICE NONREIMBURSABLE SERVICE         Uther         0         0         0         0         0         36.00           36.00	24.00	Sedatives / Hypnotics	0		0		0	0	0	24.00
27.00       Pati ent Transportation       0       0       0       0       27.00         28.00       Imaging Services       0       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       0       29.00         30.00       Medical Supplies       0       0       0       0       29.00         31.00       Outpati ent Services (including E/R Dept.)       0       0       0       0       30.00         32.00       Radiation Therapy       0       0       0       0       31.00         32.00       Chemotherapy       0       0       0       0       32.00         33.00       Chemotherapy       0       0       0       0       33.00         34.00       Other       0       0       0       0       34.00         HOSPICE NONREIMBURSABLE SERVICE         HOSPICE NONREIMBURSABLE SERVICE         Total Sing         35.00       Bereavement Program Costs       0       0       0       0       36.00         36.00       Vol unteer Program Costs       0       0       0       0       0       37.00 <td>25.00</td> <td>Other - Specify</td> <td>0</td> <td></td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>25.00</td>	25.00	Other - Specify	0		0		0	0	0	25.00
27.00       Pati ent Transportation       0       0       0       0       27.00         28.00       Imaging Services       0       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       0       29.00         30.00       Medical Supplies       0       0       0       0       29.00         31.00       Outpati ent Services (including E/R Dept.)       0       0       0       0       30.00         32.00       Radiation Therapy       0       0       0       0       31.00         32.00       Chemotherapy       0       0       0       0       32.00         33.00       Chemotherapy       0       0       0       0       33.00         34.00       Other       0       0       0       0       34.00         HOSPICE NONREIMBURSABLE SERVICE         HOSPICE NONREIMBURSABLE SERVICE         Total Sing         35.00       Bereavement Program Costs       0       0       0       0       36.00         36.00       Vol unteer Program Costs       0       0       0       0       0       37.00 <td>26.00</td> <td>Durable Medical Equipment/Oxygen</td> <td>0</td> <td></td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>26.00</td>	26.00	Durable Medical Equipment/Oxygen	0		0		0	0	0	26.00
29.00       Labs and Diagnostics       0       0       0       0       29.00         30.00       Medical Supplies       0       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       0       32.00         33.00       Chemotherapy       0       0       0       0       33.00         34.00       Other       0       0       0       0       0       33.00         HOSPICE NONREI MBURSABLE SERVICE         ***********************************	27.00		0		0		0	0	0	27.00
30.00       Medical Supplies       0       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       0       0       32.00         33.00       Chemotherapy       0       0       0       0       0       33.00         34.00       Other       0       0       0       0       0       0       33.00         HOSPICE NONREI MBURSABLE SERVICE         ***********************************	28.00	Imaging Services	0		0		0	0	0	28.00
31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       0       32.00         33.00       Chemotherapy       0       0       0       0       33.00         34.00       Other       0       0       0       0       33.00         HOSPICE NONREI MBURSABLE SERVICE         HOSPICE NONREI MBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       0       36.00         37.00       Fundrai si ng       0       0       0       0       37.00         38.00       Other Program Costs       0       0       0       0       38.00	29.00	Labs and Diagnostics	0		0		0	0	0	29.00
32.00       Radiation Therapy       0       0       0       0       32.00         33.00       Chemotherapy       0       0       0       0       33.00         34.00       Other       0       0       0       0       0       34.00         HOSPICE NONREI MBURSABLE SERVICE	30.00	Medical Supplies	0		0		0	0	0	30.00
33.00       Chemotherapy       0       0       0       0       33.00         34.00       Other       0       0       0       0       34.00         HOSPICE NONREIMBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       0       36.00         37.00       Fundrai si ng       0       0       0       0       37.00         38.00       Other Program Costs       0       0       0       0       38.00	31.00	Outpatient Services (including E/R Dept.)	0		0		0	0	0	31.00
33.00       Chemotherapy       0       0       0       0       33.00         34.00       Other       0       0       0       0       34.00         HOSPICE NONREIMBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       0       36.00         37.00       Fundrai si ng       0       0       0       0       37.00         38.00       Other Program Costs       0       0       0       0       38.00	32.00	Radiation Therapy	0		0		0	0	0	32.00
34.00         Other         0         0         0         0         0         34.00           HOSPI CE NONREI MBURSABLE SERVI CE           35.00         Bereavement Program Costs         0         0         0         0         35.00           36.00         Vol unteer Program Costs         0         0         0         0         36.00         36.00         36.00         37.00         38.00         0         0         0         0         37.00         38.00         0         0         0         0         38.00         0         0         0         0         38.00         0         0         0         0         38.00         0         0         0         0         38.00	33.00		0		0		0	0	0	33.00
35.00         Bereavement Program Costs         0         0         0         0         35.00           36.00         Vol unteer Program Costs         0         0         0         0         36.00           37.00         Fundraising         0         0         0         0         0         37.00           38.00         Other Program Costs         0         0         0         0         38.00	34.00	1.5	0		0		0	0	0	34.00
36.00         Volunteer Program Costs         0         0         0         0         36.00           37.00         Fundraising         0         0         0         0         0         37.00           38.00         Other Program Costs         0         0         0         0         0         38.00		HOSPI CE NONREI MBURSABLE SERVI CE				•				
37.00         Fundraising         0         0         0         0         37.00           38.00         Other Program Costs         0         0         0         0         0         38.00	35.00	Bereavement Program Costs	0		0		0	0	0	35.00
38.00         Other Program Costs         0         0         0         0         38.00	36.00	Volunteer Program Costs	0		0		0	0	0	36.00
	37.00	Fundrai si ng	0		0		0	0	0	37.00
39.00         Total (sum of lines 1 thru 38)         271,425         0         271,425         0         271,425         39.00	38.00	Other Program Costs	0		0		0	0	0	38.00
	39.00	Total (sum of lines 1 thru 38)	271, 425		0	271, 4	25	0	271, 425	39.00

Heal th	Financial Systems	JASPER COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
	E COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der	CCN: 151324	Peri od:	Worksheet K-1	
			Hospi ce C	CN: 151519	From 01/01/2015 To 08/31/2015	Date/Time Pre 8/15/2016 3:5	
					Hospi ce I	0/10/2010 0.0	
		Admi ni strator	Di rector	Soci al Servi ces	Supervi sors	Nurses	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1100	2.00	0100		0100	
1.00	Capital Related Costs-Bldg and Fixt.						1 1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0		0 0	0	3.00
4.00	Transportation - Staff	0	0		0 0	0	4.00
5.00	Volunteer Service Coordination	0	0		0 0	0	5.00
6.00	Administrative and General	11, 882	0		0 0	0	6.00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0	0		0 0	0	7.00
8.00	Inpatient - Respite Care	0	0		0 0	0	8.00
	VI SI TI NG SERVI CES	· · · · ·					1
9.00	Physi ci an Servi ces	0	0		0 0	0	9.00
10.00	Nursing Care	0	0		0 0	25, 376	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	11.00
12.00	Physical Therapy	0	0		0 0	0	12.00
13.00	Occupational Therapy	0	0		0 0	0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0 0	0	14.00
15.00	Medical Social Services	0	0	34, 7	45 0	0	15.00
16.00	Spiritual Counseling	0	0		0 0	0	16.00
17.00	Di etary Counsel i ng	0	0		0 0	0	17.00
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20.00
21.00	Other	0	0		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22.00
23.00	Anal gesi cs						23.00
24.00	Sedatives / Hypnotics						24.00
25.00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27.00	Patient Transportation	0	0		0 0	0	
28.00	Imaging Services	0	0		0 0	0	
29.00	Labs and Diagnostics	0	0		0 0	0	
30.00	Medical Supplies	0	0		0 0	0	
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	
32.00	Radiation Therapy	0	0		0 0	0	
33.00	Chemotherapy	0	0		0 0	0	
34.00		0	0		0 0	0	34.00
05 66	HOSPI CE NONREI MBURSABLE SERVI CE					2	05 00
35.00	Bereavement Program Costs	0	0		0 0	0	
36.00	Volunteer Program Costs	0	0		0 0	0	
37.00	Fundrai si ng	0	0		0 0	0	
38.00	Other Program Costs	11 000	0	24 7	0 0	0	
39.00	Total (sum of lines 1 thru 38)	11, 882	0	34, 7	45 0	25, 376	39.00

Heal th	Financial Systems	JASPER COUNTY	HOSPI TAL		In Lie	u of Form CMS-2552-10
	E COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der (	CCN: 151324	Peri od:	Worksheet K-1
					From 01/01/2015	
			Hospi ce C	CN: 151519	To 08/31/2015	Date/Time Prepared:
						8/15/2016 3:56 pm
		Tatal	A :		Hospi ce I	
		Total	Ai des	All-Other	Total (1)	
		Therapists 6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	9.00	
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Brug and Trxt:					2.00
3.00	Plant Operation and Maintenance		0		0 0	3.00
4.00	Transportation - Staff		0		0 0	4.00
5.00	Volunteer Service Coordination		0		0 0	5.00
6.00	Administrative and General		0	29, 0	0	6.00
0.00	I NPATI ENT_CARE_SERVI CE		<u> </u>	27,0	10 40,070	0.00
7.00	Inpatient - General Care		0		0 0	7.00
8.00	Inpatient - Respite Care		0		0 0	8.00
0.00	VI SI TI NG SERVI CES	I	Ÿ			0.00
9.00	Physician Services		0		0 0	9,00
10.00	Nursi ng Care		0		0 25, 376	10.00
11.00	Nursing Care-Continuous Home Care		0		0 23, 370	11.00
12.00	Physical Therapy	0	0		0 0	12.00
13.00	Occupational Therapy	0	0		0 0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0 0	14.00
15.00	Medi cal Social Services	0	0		0 34, 745	15.00
16.00	Spiritual Counseling		0		0 0	16.00
17.00	Di etary Counsel i ng		0		0 0	17.00
18.00	Counseling - Other		0		0 0	18.00
19.00	Home Health Aide and Homemaker		2, 665		0 2,665	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		2,000		0 0	20.00
21.00	Other		0		0 0	21.00
21.00	OTHER HOSPICE SERVICE COSTS		9		0	21.00
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Anal gesi cs					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0		0 0	27.00
28.00	I magi ng Servi ces		0		0 0	28.00
29.00	Labs and Diagnostics		0		0 0	29.00
30.00	Medical Supplies		0		0 0	30.00
31.00	Outpatient Services (including E/R Dept.)		0		0 0	31.00
32.00	Radi ati on Therapy		0		0 0	32.00
33.00	Chemotherapy		Ő		0 0	33.00
34.00	Other		Ő		0 0	34.00
2.1.00	HOSPI CE NONREI MBURSABLE SERVI CE	· ·	V			
35.00	Bereavement Program Costs		0		0 0	35.00
36.00	Volunteer Program Costs		0		0 0	36.00
37.00	Fundrai si ng		Ő		0 0	37.00
38.00	Other Program Costs		o		0 0	38.00
	Total (sum of lines 1 thru 38)	0	2, 665	29, 0	16 103, 684	39.00
	,	-1				

COST ALLOCATION - HOSPICE GENERAL SERVICE COST         Provide CCN:         10124         Provide CCN:         10124         Provide CCN:         1010/2015         Provide CCN:         Provid CCN:         Provide CCN:         <	Heal th	Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CAPITAL RELATED COST         Hospice 1           CAPITAL RELATED COST         MOVABLE FOR COST         PLANT PLANT         PLANT OPERATION & AMAINT           00         Capital Related Costs - Bidg and Fixt.         0         2.00         3.00         4.00           1.00         Capital Related Costs - Bidg and Fixt.         0         0         0         0         2.00         3.00           2.00         Capital Related Costs - Movable Equip.         0				Provi der		Period: From 01/01/2015	Worksheet K-4 Part I Date/Time Pre	pared:
EXERCISE         CAPITAL RELATED COST BUILDINGS & ALLOCATION         PLANT FOR COST ALLOCATION         PLANT PRANSPORTATION           1:00         Capital Related Costs-Bidg and Fixt. 0         0         1.00         2.00         3.00         4.00           1:00         Capital Related Costs-Bidg and Fixt. 0         0         0         0         1.00         3.00         4.00           2:00         Plant Operation and Maintename 0         0						Hochi co. I	8/15/2016 3:50	6 pm
NET EXPENSES FOR COST ALLOCATION         BUILDINGS & FIXTURES         MOVABLE FOULPRINT         PLANT OPERATION & MUNT         TRANSPORTATION           0         0         2.00         3.00         4.00           1.00         2.00         3.00         4.00           0         0         0         0         0         1.00           0         0         0         0         0         1.00         2.00         3.00         4.00           1.00         Capital Related Costs-Bidg and Fixt.         0		· · · · ·			LATED COST			
FOR COST         FIXTURES         EQUIPMENT         OPERATION & MAINT           0         1.00         2.00         3.00         4.00           0         0         1.00         2.00         3.00         4.00           0         0         2.00         3.00         4.00         1.00           0         Capital Related Costs-Budgian Equip.         0         0         2.00         3.00           3.00         Plant Operation and Maintenance         0         0         0         0         4.00           0         0         0         0         0         0         0         4.00           1.00         Using Careria         208.63         0         0         0         6.00           1.00         Instrative and Ceneral         208.63         0         0         0         6.00           1.00         Instrative and Ceneral Care         0 <td< td=""><td></td><td></td><td></td><td></td><td>LATED COST</td><td></td><td></td><td></td></td<>					LATED COST			
CENERAL SERVICE COST CENTERS         0         1.00         2.00         3.00         4.00           1.00         Capital Related Costs-Bobade Equip.         0			FOR COST			OPERATION &	TRANSPORTATI ON	
CENERAL SERVICE COST CENTRES         Image: Cost of the service								
1.00         Capital Related Costs-Bidg and Fixt.         0         0         1.00           2.00         Capital Related Costs-Movable Equip.         0         0         0         3.00           2.00         Capital Related Costs-Movable Equip.         0         0         0         3.00           3.00         Plant Operation and Maintenance         0         0         0         0         3.00           0.00         Volunteer Service Coordination         0			0	1.00	2.00	3.00	4.00	
2.00         Capital Related Costs-Movable Equip.         0         0         2.00         2.00         0 </td <td>1 00</td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>1 00</td>	1 00			0				1 00
3.00         Plant Operation and Maintenance         0         0         0         3.00           4.00         Transportation - Staff         0			-	0				
4.00         Transportation - Staff         0 <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>			-					
5.00         Volunteer Service Coordination         0			-	-				
6.00         Administrative and General         208,639         0			-	-				
INPATIENT CARE SERVICE         Image: Control of the control of			-					
7.00         Inpatient - General Care         0<	6.00		208, 639	0		0 0	0	6.00
8.00         Inpatient - Respite Care         0<	7 00			0			0	7 00
VISITING SERVICES         0								
9.00         Physician Services         0	8.00		0	0		0 0	0	8.00
10.00         Nursing Care         25,376         0         0         0         0         10.00           11.00         Nursing Care-Continuous Home Care         0	0.00			0		0	0	0.00
11.00         Nursing Care-Continuous Home Care         0         0         0         0         0         11.00           12.00         Physical Therapy         0         0         0         0         0         0         12.00           13.00         Occupational Therapy         0         0         0         0         0         0         12.00           14.00         Speech Language Pathol gy         0         0         0         0         0         0         0         0         0         0         0         13.00           15.00         Medical Social Services         34.745         0			-					
12.00       Physical Therapy       0       0       0       0       0       12.00         13.00       Occupational Therapy       0       0       0       0       0       13.00         14.00       Speech/ Language Pathology       0       0       0       0       0       13.00         15.00       Medical Social Services       34,745       0       0       0       15.00         16.00       Spiritual Counseling       0       0       0       0       16.00         17.00       Dietary Counseling       0       0       0       0       17.00         18.00       Counseling - Other       0       0       0       0       18.00         19.00       Home Healt haide and Homemaker       2.665       0       0       0       20.00         20.00       Drugs, Biological and Infusion Therapy       0       0       0       0       21.00         0       Ofther       0       0       0       0       22.00       23.00         21.00       Ortugs, Biological and Infusion Therapy       0       0       0       22.00       23.00         23.00       Anal gesics       0       0       0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
13.00       Occupational Therapy       0       0       0       0       0       13.00         14.00       Speech/Language Pathol ogy       0       0       0       0       0       14.00         15.00       Medical Social Services       34,745       0       0       0       0       14.00         16.00       Spiritual Counseling       0       0       0       0       0       16.00         17.00       Dietary Counseling       0       0       0       0       0       16.00         18.00       Counseling - Other       0       0       0       0       18.00         19.00       Home Health Aide and Homemaker       2,665       0       0       0       0       19.00         20.00       Pther       Object SERVICE COSTS       0       0       0       21.00         21.00       Other       0       0       0       0       22.00       23.00         24.00       Sedatives / Hypnotics       0       0       0       0       22.00         25.00       Ourable Medical Equipment/0xygen       0       0       0       24.00       24.00         25.00       Durable Medical Services </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
14.00       Speech/Language Pathology       0       0       0       0       0       0       14.00         15.00       Medical Social Services       34,745       0       0       0       0       15.00         16.00       Spiritual Counseling       0       0       0       0       0       0       16.00         17.00       Dietary Counseling       0       0       0       0       0       17.00         18.00       Counseling - Other       0       0       0       0       0       18.00         20.00       HH Aide and Homemaker       2,665       0       0       0       21.00         0       0       0       0       0       0       0       22.00         11.00       Other       0       0       0       0       22.00         21.00       Drugs, Biological and Infusion Therapy       0       0       0       22.00         23.00       Anal gesics       0       0       0       22.00         24.00       Sedatives / Hypnotics       0       0       0       24.00         25.00       Other - Specify       0       0       0       27.00      <			-	-				
15.00       Médical Social Services       34,745       0       0       0       0       15.00         16.00       Spiritual Counseling       0			-	-		-		
16.00       Spiritual Counseling       0 </td <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td></td> <td></td> <td></td>			-	-				
17.00       Dietary Counseling       0       0       0       0       0       0       0       17.00         18.00       Counseling - Other       0       0       0       0       0       0       0       18.00         19.00       Home Healt Aide and Homemaker       2,665       0       0       0       0       19.00         20.00       HH Aide & Homemaker - Cont. Home Care       0								
18.00       Counseling - Other       0       0       0       0       18.00         19.00       Home Heal th Aide and Homemaker       2,665       0       0       0       19.00         20.00       HH Aide & Homemaker - Cont. Home Care       0			-	-		-		
19.00       Home Heal th Ai de and Homemaker       2,665       0 <td></td> <td></td> <td>-</td> <td>-</td> <td></td> <td></td> <td></td> <td></td>			-	-				
20.00         HH Ai de & Homemaker - Cont. Home Care         0		5	-	-				
21.00         Other         0				-				
OTHER HOSPICE SERVICE COSTS           22.00         Drugs, Biological and Infusion Therapy         0         0         0         0         22.00           23.00         Anal gesics         0         0         0         0         0         23.00           24.00         Sedatives / Hypnotics         0         0         0         0         0         23.00           24.00         Sedatives / Hypnotics         0         0         0         0         24.00           25.00         Other - Specify         0         0         0         0         25.00           26.00         Durable Medical Equipment/Oxygen         0         0         0         0         26.00           27.00         Patient Transportation         0         0         0         0         27.00           28.00         Imaging Services         0         0         0         0         28.00           29.00         Labs and Diagnostics         0         0         0         0         29.00           30.00         Medical Supplies         0         0         0         0         30.00           31.00         Outpatient Services (including E/R Dept.)         0         0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
22.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       22.00         23.00       Analgesics       0       0       0       0       0       23.00         24.00       Sedatives / Hypnotics       0       0       0       0       0       23.00         24.00       Sedatives / Hypnotics       0       0       0       0       0       23.00         24.00       Sedatives / Hypnotics       0       0       0       0       0       24.00         25.00       Other - Specify       0       0       0       0       25.00       0       26.00       0       0       0       25.00       0       0       0       26.00       0       26.00       0       0       0       26.00       0       0       0       27.00       28.00       0       0       0       0       28.00       0       0       0       0       28.00       0       0       0       0       29.00       28.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	21.00		0	0		0 0	0	21.00
23.00       Analgesics       0       0       0       0       23.00         24.00       Sedatives / Hypnotics       0       0       0       0       24.00         25.00       Other - Specify       0       0       0       0       25.00         26.00       Durable Medical Equipment/Oxygen       0       0       0       0       26.00         26.00       Patient Transportation       0       0       0       0       26.00         27.00       Patient Transportation       0       0       0       0       27.00         28.00       Imaging Services       0       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       0       29.00         30.00       Medical Supplies       0       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       0       0       33.00         34.00       Other       0       0       0       0       0       0       0       34.00					[			
24.00       Sedatives / Hypnotics       0       0       0       0       0       24.00         25.00       Other - Specify       0       0       0       0       0       25.00         26.00       Durable Medical Equipment/Oxygen       0       0       0       0       26.00         27.00       Patient Transportation       0       0       0       0       27.00         28.00       Imaging Services       0       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       0       29.00         30.00       Medical Supplies       0       0       0       0       29.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       30.00         32.00       Radiation Therapy       0       0       0       0       33.00         33.00       Chemotherapy       0       0       0       0       33.00         34.00       Other       0       0       0       0       0       34.00         46.00       Vol unteer Program Costs       0       0       0       0       35.00			-	-				
25.00       Other - Specify       0       0       0       0       25.00         26.00       Durable Medical Equipment/Oxygen       0       0       0       0       26.00         27.00       Patient Transportation       0       0       0       0       26.00         27.00       Patient Transportation       0       0       0       0       27.00         28.00       Imaging Services       0       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       0       29.00         30.00       Medical Supplies       0       0       0       0       0       29.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       30.00         32.00       Radiation Therapy       0       0       0       0       31.00         32.00       Chemotherapy       0       0       0       0       32.00         33.00       Chemotherapy       0       0       0       0       34.00         HOSPICE NONREI MBURSABLE SERVICE			-					
26.00       Durable Medical Equipment/Oxygen       0       0       0       0       0       26.00         27.00       Patient Transportation       0       0       0       0       0       27.00         28.00       Imaging Services       0       0       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       0       29.00         30.00       Medical Supplies       0       0       0       0       29.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       0       0       32.00         33.00       Chemotherapy       0       0       0       0       0       33.00         34.00       Other       0       0       0       0       0       0       34.00         HOSPICE NONRELIMBURSABLE SERVICE         Total asing       0       0       0       0       35.00         Services       0       0       0       0       0       36.00         HOSPICE NON			-					
27.00       Pati ent Transportation       0       0       0       0       27.00         28.00       Imaging Services       0       0       0       0       28.00         29.00       Labs and Di agnostics       0       0       0       0       29.00         30.00       Medical Supplies       0       0       0       0       29.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       30.00         32.00       Radiation Therapy       0       0       0       0       31.00         32.00       Chemotherapy       0       0       0       0       32.00         33.00       Chemotherapy       0       0       0       0       33.00         34.00       Other       0       0       0       0       34.00         HOSPICE NONRELIMBURSABLE SERVICE         Total Sing         35.00       Bereavement Program Costs       0       0       0       0       36.00         36.00       Vol unteer Program Costs       0       0       0       0       37.00         38.00       Other Program Costs       0 <td< td=""><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td><td></td></td<>			-					
28.00       Imaging Services       0       0       0       0       28.00         29.00       Labs and Diagnostics       0       0       0       0       29.00         30.00       Medical Supplies       0       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       0       32.00         33.00       Chemotherapy       0       0       0       0       32.00         34.00       Other       0       0       0       0       33.00         HOSPICE NONREIMBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       0       36.00         37.00       Fundraising       0       0       0       0       0       37.00         38.00       Other Program Costs       0       0       0       0       0       38.00			-	-				
29.00       Labs and Diagnostics       0       0       0       0       29.00         30.00       Medical Supplies       0       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       0       0       32.00         33.00       Chemotherapy       0       0       0       0       0       33.00         34.00       Other       0       0       0       0       0       0       33.00         HOSPICE NONREI MBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       0       36.00       37.00       36.00       37.00         38.00       Other Program Costs       0       0       0       0       0       0       37.00			-	-			-	
30.00       Medical Supplies       0       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       0       0       32.00         33.00       Chemotherapy       0       0       0       0       0       33.00         34.00       Other       0       0       0       0       0       0       33.00         HOSPICE NONREI MBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       0       0       36.00         37.00       Fundraising       0       0       0       0       0       37.00         38.00       Other Program Costs       0       0       0       0       0       38.00			-	-		-		
31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       0       32.00         33.00       Chemotherapy       0       0       0       0       0       32.00         34.00       Other       0       0       0       0       0       33.00         HOSPICE NONREI MBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       0       36.00       36.00       37.00       38.00       0       0       0       0       37.00         38.00       Other Program Costs       0       0       0       0       0       38.00			-					
32.00       Radiation Therapy       0       0       0       0       32.00         33.00       Chemotherapy       0       0       0       0       0       33.00         34.00       Other       0       0       0       0       0       33.00         HOSPICE NONREI MBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       0       36.00         37.00       Fundrai si ng       0       0       0       0       0       37.00         38.00       Other Program Costs       0       0       0       0       0       38.00				-				
33.00       Chemotherapy       0       0       0       0       33.00         34.00       Other       0       0       0       0       0       34.00         HOSPICE NONREIMBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       0       36.00         37.00       Fundrai si ng       0       0       0       0       37.00         38.00       Other Program Costs       0       0       0       0       38.00			-	-				
34.00         Other         0         0         0         0         0         0         34.00           HOSPICE NONREI MBURSABLE SERVICE			-	-		-		
HOSPICE NONREI MBURSABLE SERVICE           35.00         Bereavement Program Costs         0         0         0         0         35.00           36.00         Vol unteer Program Costs         0         0         0         0         36.00           37.00         Fundraising         0         0         0         0         0         37.00           38.00         Other Program Costs         0         0         0         0         0         38.00		13	-	-				
35.00         Bereavement Program Costs         0         0         0         0         35.00           36.00         Vol unteer Program Costs         0         0         0         0         36.00           37.00         Fundraising         0         0         0         0         0         37.00           38.00         Other Program Costs         0         0         0         0         38.00	34.00		0	0		0 0	0	34.00
36.00         Volunteer Program Costs         0         0         0         0         36.00           37.00         Fundraising         0         0         0         0         0         37.00           38.00         Other Program Costs         0         0         0         0         0         38.00	25 22					0		25 22
37.00         Fundraising         0         0         0         0         37.00           38.00         Other Program Costs         0         0         0         0         0         38.00			-	-		-		
38.00         Other Program Costs         0         0         0         0         0         38.00			-	-				
		5	-					
39. UU [TOTAL (SUM OF LINES I TITU 38)   2/1,425  U  U  U  U  0  0  39. 00			-					
	39.00	Total (Sum of Tines I Thru 38)	271, 425	0	l	U] 0	0	39.00

Heal th	Financial Systems	JASPER COUNT	TY HOSE	PI TAL		In Lie	eu of Form CMS-	2552-10
	ALLOCATION - HOSPICE GENERAL SERVICE COST			Provi der	CCN: 151324 CCN: 151519	Period: From 01/01/2015 To 08/31/2015	Worksheet K-4 Part I	l epared:
						Hospi ce I	0, 10, 2010 010	
		VOLUNTEER	SU	BTOTAL	ADMI NI STRATI	VETOTAL (col. 5A		
		SERVI CES COORDI NATOR		. 0 - 5)	& GENERAL	± col. 6)		
	1	5.00		5A	6.00	7.00		
	GENERAL SERVICE COST CENTERS				1		1	_
1.00	Capital Related Costs-Bldg and Fixt.							1.00
2.00	Capital Related Costs-Movable Equip.							2.00
3.00	Plant Operation and Maintenance							3.00
4.00	Transportation - Staff							4.00
5.00	Volunteer Service Coordination	0						5.00
6.00	Administrative and General	0	)	208, 639	208, 6	39		6.00
	I NPATI ENT CARE SERVI CE							
7.00	Inpatient - General Care	0	)	0		0 0		7.00
8.00	Inpatient - Respite Care	0		0		0 0		8.00
	VISITING SERVICES							
9.00	Physi ci an Servi ces	0	)	0		0 0		9.00
10.00	Nursing Care	0		25, 376	84, 3	25 109, 701		10.00
11.00	Nursing Care-Continuous Home Care	0		0		0 0		11.00
12.00	Physical Therapy	0		C		0 0		12.00
13.00	Occupational Therapy	0		C		0 0		13.00
14.00	Speech/ Language Pathology	0		0		0 0		14.00
15.00	Medical Social Services	0		34, 745	115, 4	58 150, 203		15.00
16.00	Spiritual Counseling	0		0		0 0		16.00
17.00	Dietary Counseling	0		0		0 0		17.00
18.00	Counseling - Other	0		0		0 0		18.00
19.00	Home Health Aide and Homemaker	0		2,665	8,8	56 11, 521		19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0		2,000	0,0	0 0		20.00
21.00	Other	0		0		0 0		21.00
21.00	OTHER HOSPICE SERVICE COSTS	0	<u>′</u>			0 0		21.00
22.00	Drugs, Biological and Infusion Therapy	0		0		0 0		22.00
22.00	Anal gesi cs	0		0		0 0		23.00
24.00	Sedatives / Hypnotics	0		0		0 0		24.00
24.00	Other - Specify	0	(	0				24.00
		0	<u>'</u>	0				
26.00	Durable Medical Equipment/Oxygen Patient Transportation		<u>'</u>	0				26.00
27.00	1	0	<u>'</u>			-		27.00
28.00	Imaging Services	0	<u>'</u>	0		0 0		28.00
29.00	Labs and Diagnostics	0	2	0		0 0		29.00
30.00	Medi cal Supplies	0	2	0		0 0		30.00
31.00	Outpatient Services (including E/R Dept.)	0	2	0		0 0		31.00
32.00	Radi ati on Therapy	0	1	0		0 0		32.00
33.00	Chemotherapy	0		0		0 0		33.00
34.00	Other	0	0	0		0 0		34.00
	HOSPICE NONREIMBURSABLE SERVICE	1	1		1		1	
35.00	Bereavement Program Costs	0		0		0 0		35.00
36.00	Volunteer Program Costs	0		0		0 0		36.00
37.00	Fundrai si ng	0		0		0 0		37.00
38.00	Other Program Costs	0		0		0 0		38.00
39.00	Total (sum of lines 1 thru 38)	0	9	271, 425		271, 425		39.00

Heal th	Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
	LLOCATION - STATISTICAL BASIS			CCN: 151324	Period: From 01/01/2015	Worksheet K-4 Part II	
			Hospi ce (	CCN: 151519	To 08/31/2015	Date/Time Pre 8/15/2016 3:5	
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON		
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION 8	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ. FT.)		COORDI NATOR (HOURS)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS			1			
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0		0		2.00 3.00
3.00 4.00	Plant Operation and Maintenance Transportation - Staff	0	0		0 0		4.00
4.00 5.00	Volunteer Service Coordination	0	0		0 0	0	
6.00	Administrative and General	0	0		0 0	0	
0.00	I NPATI ENT_CARE_SERVI CE	0	0		0 0	0	0.00
7.00	Inpatient - General Care	0	0		0 0	0	7.00
8.00	Inpatient - Respite Care	0	0		0 0		
	VI SI TI NG SERVI CES			1	-		
9.00	Physi ci an Servi ces	0	0		0 0	0	9.00
10.00	Nursing Care	0	0		0 0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	
12.00	Physical Therapy	0	0		0 0	0	
13.00	Occupational Therapy	0	0		0 0	0	
14.00	Speech/ Language Pathol ogy	0	0		0 0	0	
15.00	Medical Social Services	0	0		0 0	0	
16.00	Spiritual Counseling	0	0		0 0	0	1
17.00 18.00	Dietary Counseling Counseling - Other	0	0		0 0	0	
19.00	Home Health Aide and Homemaker	0	0		0 0	0	
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	
21.00	Other	0	0		0 0	0	
21100	OTHER HOSPICE SERVICE COSTS	0		1	0 0		2
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22.00
23.00	Anal gesi cs	0	0		0 0	0	23.00
24.00	Sedatives / Hypnotics	0	0		0 0	0	24.00
25.00	Other - Specify	0	0		0 0	0	
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	
27.00	Patient Transportation	0	0		0 0	0	
28.00	I maging Services	0	0		0 0	0	
29.00	Labs and Diagnostics	0	0		0 0	0	
30.00	Medical Supplies	0	0		0 0	0	1
31.00 32.00	Outpatient Services (including E/R Dept.) Radiation Therapy	0	0		0 0	0	
32.00 33.00	Chemotherapy	0	0		0 0	0	
34.00	Other	0	0		0 0	0	
01100	HOSPI CE NONREI MBURSABLE SERVI CE	0		1	<u> </u>		
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0	0	36.00
37.00	Fundrai si ng	0	0		0 0	0	37.00
38.00	Other Program Costs	0	0		0 0	0	
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0		0 0	0	
40.00	Unit Cost Multiplier	0.000000	0. 000000	0.0000	0. 000000	0.000000	40.00

	Financial Systems	JASPER COUNTY				u of Form CMS-	
COST A	ALLOCATION - STATISTICAL BASIS			CCN: 151324 CN: 151519	Period: From 01/01/2015 To 08/31/2015	Worksheet K-4 Part II Date/Time Pre	epared:
					Hocpi co. I	8/15/2016 3:5	56 pm
		RECONCILIATION AD			Hospi ce I		
		RECONCILIATIONAL	& GENERAL				
			(ACC. COST)				
		6A	6.00				
	GENERAL SERVICE COST CENTERS	· · · ·	· · ·				
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0					2.00
3.00	Plant Operation and Maintenance	0					3.00
4.00	Transportation - Staff	0					4.00
5.00	Volunteer Service Coordination						5.00
6.00	Administrative and General	-208, 639	62, 786				6.00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0	0				7.00
8.00	Inpatient - Respite Care	0	0				8.00
	VI SI TI NG SERVI CES						
9.00	Physician Services	0	0				9.00
10.00	Nursing Care	0	25, 376				10.00
11.00	Nursing Care-Continuous Home Care	0	0				11.00
12.00	Physi cal Therapy	0	0				12.00
13.00	Occupational Therapy	0	0				13.00
14.00	Speech/ Language Pathol ogy	0	0				14.00
15.00	Medical Social Services	0	34, 745				15.00
16.00	Spiritual Counseling	0	0				16.00
17.00	Dietary Counseling	0	0				17.00
18.00	Counseling - Other	0	0				18.00
19.00	Home Health Aide and Homemaker	0	2, 665				19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0				20.00
21.00	Other	0	0				21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0	0				22.00
23.00	Anal gesi cs	0	0				23.00
24.00	Sedatives / Hypnotics	0	0				24.00
25.00	Other - Specify	0	0				25.00
26.00	Durable Medical Equipment/Oxygen	0	0				26.00
27.00	Patient Transportation	0	0				27.00
28.00	Imaging Services	0	0				28.00
29.00	Labs and Diagnostics	0	0				29.00
30.00	Medical Supplies	0	0				30.00
31.00	Outpatient Services (including E/R Dept.)	0	o				31.00
32.00	Radiation Therapy	0	o				32.00
33.00	Chemotherapy	0	o				33.00
34.00	Other	0	0				34.00
	HOSPI CE NONREI MBURSABLE SERVI CE						
35.00	Bereavement Program Costs	0	0				35.00
36.00	Volunteer Program Costs	0	o				36.00
37.00	Fundrai si ng	0	o				37.00
38.00	Other Program Costs	0	o				38.00
39.00	Cost to be Allocated (per Wkst. K-4, Part I)		208, 639				39.00
	Unit Cost Multiplier	1 1	3. 323018				40.00

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST	T CENTERS	Provi der Hospi ce (	CCN: 151324 CCN: 151519	Period: From 01/01/2015 To 08/31/2015		pared:
				Hospi ce I		
Cost Center Description	Hospice Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS	Subtotal	ADMI NI STRATI VE & GENERAL	
		1.00	DEPARTMENT		5.00	
	0	1.00	4.00	4A	5.00	1 00
1.00 Administrative and General		4, 135		06 32, 941	6, 515	1.00
2.00 Inpatient - General Care	0	0	)	0 0	0	2.00
3.00 Inpatient - Respite Care	0	0	)	0 0	0	3.00
4.00 Physician Services	0	C	)	0 0	0	4.00
5.00 Nursing Care	109, 701	0	)	0 109, 701		5.00
6.00 Nursing Care-Continuous Home Care	0	0	)	0 0	0	6.00
7.00 Physical Therapy	0	0	)	0 0	0	7.00
8.00 Occupational Therapy	0	0	)	0 0	0	8.00
9.00 Speech/ Language Pathol ogy	0	0		0 0	0	9.00
10.00 Medical Social Services	150, 203	0		0 150, 203	29, 707	10.00
11.00 Spiritual Counseling	0	0	)	0 0	0	11.00
12.00 Dietary Counseling	0	0	)	0 0	0	12.00
13.00 Counseling - Other	0	0	)	0 0	0	13.00
14.00 Home Health Aide and Homemaker	11, 521	0	)	0 11, 521	2, 279	14.00
15.00   HH Aide & Homemaker - Cont. Home Care	0	0	)	0 0	0	15.00
16.00 Other	0	0		0 0	0	16.00
17.00 Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00 Anal gesi cs	0	0		0 0	0	18.00
19.00 Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00 Other - Specify	0	0		0 0	0	20.00
21.00 Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00 Patient Transportation	0	0		0 0	0	22.00
23.00 Imaging Services	0	0		0 0	0	23.00
24.00 Labs and Diagnostics	0	C		0 0	0	24.00
25.00 Medical Supplies	0	0		0 0	0	25.00
26.00 Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00 Radiation Therapy	0	l o		0 0	0	27.00
28.00 Chemotherapy	0	l o		0 0	0	28.00
29.00 Other	0	c c		0 0	0	29.00
30.00 Bereavement Program Costs	0	l o		0 0	0	30.00
31.00 Volunteer Program Costs	0	l o		0 0	0	31.00
32.00 Fundrai si ng	0	0		0 0	0	32.00
33.00 Other Program Costs	0	l o		0 0	0	33.00
34.00 Total (sum of lines 1 thru 33) (2)	271, 425	4, 135	28, 8	304, 366	60, 198	34.00
35.00 Unit Cost Multiplier (see instructions)				0		35.00

Heal th	Financial Systems	JASPER COUNT	TY HOS	PI TAL				In Lie	u of Form CMS-2	2552-10
ALLOCA	ATION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		Provi der	CCN: 1513			ri od:	Worksheet K-5	
				Hospice C	CN. 1E1		Frc To	om 01/01/2015 08/31/2015		narod
				nospi ce c	CN. 151:	519	10	06/31/2015	8/15/2016 3:5	
								Hospi ce I		
	Cost Center Description	OPERATION OF	LAU	JNDRY &	HOUSEKEE	PING	i	DIETARY	CAFETERI A	
		PLANT		SERVICE						
	1	7.00		8.00	9.00			10.00	11.00	
1.00	Administrative and General	2, 405		0			0	0	0	1.00
2.00	Inpatient - General Care	0		0			0	0	0	2.00
3.00	Inpatient - Respite Care	0		0			0	0	0	3.00
4.00	Physi ci an Servi ces	0		0			0	0	0	4.00
5.00	Nursing Care	0		0			0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0		0			0	0	0	6.00
7.00	Physi cal Therapy	0		0			0	0	0	
8.00	Occupational Therapy	0		0			0	0	0	
9.00	Speech/ Language Pathol ogy	0		0			0	0	0	9.00
10.00	Medical Social Services	0		0			0	0	0	
11.00	Spiritual Counseling	0		0			0	0	0	11.00
12.00	Di etary Counsel i ng	0		0			0	0	0	12.00
13.00	Counseling - Other	0		0			0	0	0	
14.00	Home Health Aide and Homemaker	0	2	0			0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		0			0	0	0	15.00
16.00	Other	0	2	0			0	0	0	
17.00 18.00	Drugs, Biological and Infusion Therapy Analgesics	0	2	0			0	0	0	17.00 18.00
18.00	Sedati ves / Hypnoti cs	0	(	0			0	0	0	
	Other - Specify	0		0			0	0	0	20.00
20.00	Durable Medical Equipment/Oxygen	0	(	0			0	0	0	20.00
21.00	Pati ent Transportati on	0	(	0			0	0	0	
22.00	Imaging Services			0			0	0	0	23.00
24.00	Labs and Diagnostics	0		0			0	0	0	24.00
25.00	Medi cal Supplies	0		0			0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0		0			0	0	0	26.00
27.00	Radi ati on Therapy	0		0			0	0	0	27.00
28.00	Chemotherapy	0		0			0	0	0	28.00
29.00	Other	0		0			0	0	0	29.00
30.00	Bereavement Program Costs	0		0			0	0	0	30.00
31.00	Volunteer Program Costs	0		0			0	0	0	
32.00	Fundrai si ng	0		0			0	0	0	32.00
33.00	Other Program Costs	0		0			0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	2, 405		0			0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)									35.00

Heal th	Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
ALLOCA	ATION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		CCN: 151324 CCN: 151519	Period: From 01/01/2015 To 08/31/2015	Worksheet K-5 Part I Date/Time Pre 8/15/2016 3:50	
					Hospi ce I		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	0	0		0 0		1.00
2.00	Inpatient - General Care	0	0		0 0	0	2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physi ci an Servi ces	0	0		0 0	0	4.00
5.00	Nursi ng Care	0	0		0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0			0	6.00
7.00	Physical Therapy	0	0			0	7.00
8.00	Occupational Therapy	0	0		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0	0			0	9.00
9.00 10.00	Medical Social Services	0	0			0	9.00 10.00
		0	0		0 0		
11.00	Spiritual Counseling	0	0			0	11.00
12.00	Di etary Counsel i ng	0	0		s	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00	Patient Transportation	0	0		0 0	0	22.00
23.00	Imaging Services	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0	0	24.00
25.00	Medical Supplies	0	0		0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radiation Therapy	0	0		0 0	0	27.00
28.00	Chemotherapy	0	0		0 0	0	28.00
29.00	Other	0	0		0 0	0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0		0 0	0	31.00
32.00	Fundrai si ng	0	0		0 0	0	32.00
33.00	Other Program Costs	0	0		0 0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0		0 0	0	34.00
	Unit Cost Multiplier (see instructions)		0				35.00
00.00		1 1		I	I	1	20.00

Heal th	Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		CCN: 151324 CCN: 151519	Period: From 01/01/2015 To 08/31/2015		pared:
					Hospi ce I		
	Cost Center Description	Subtotal	Intern &	Subtotal	Allocated	Total Hospice	
		(cols. 4A-23)	Residents Cost	(cols. 24 ±	Hospi ce A&G	Costs (cols.	
		` ` `	& Post	25)	(See Part II)		
			Stepdown		. ,	, , , , , , , , , , , , , , , , , , ,	
			Adjustments				
		24.00	25.00	26.00	27.00	28.00	
1.00	Administrative and General	41, 861					1.00
2.00	Inpatient - General Care	0	0		0 0	0	2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physician Services	0	0		0 0	0	4.00
5.00	Nursing Care	131, 398	0	131, 3	98 16, 919	148, 317	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00	Physical Therapy	0	0		0 0	0	7.00
8.00	Occupational Therapy	0	0		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	9,00
10.00	Medical Social Services	179, 910	0	179, 9	10 23, 165	203, 075	10.00
11.00	Spiritual Counseling	0	0	,.	0 0	0	11.00
12.00	Dietary Counseling	0	0		0 0		12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	13, 800	0	13, 8	00 1, 777		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00	Pati ent Transportati on	0	0			0	22.00
23.00	I maging Services	0	0		0 0	0	23.00
24.00	Labs and Di agnosti cs	0	0			0	24.00
25.00	Medical Supplies	0	0			0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0			0	26.00
27.00	Radiation Therapy	0	0			0	27.00
28.00	Chemotherapy	0	0			0	28.00
29.00	Other	0	0			0	29.00
30.00	Bereavement Program Costs	0	0			0	30.00
31.00	Volunteer Program Costs	0	0			0	31.00
31.00	Fundrai si ng	0	0			0	32.00
32.00	Other Program Costs	0	0			0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	366, 969	0	366, 9	69	366, 969	34.00
	Unit Cost Multiplier (see instructions)	300, 909	0	300, 7	0. 128760		35.00
55.50		I I		I	0. 120700	I	1 00.00

Heal th	Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	NTION OF GENERAL SERVICE COSTS TO HOSPICE COST STICAL BASIS	CENTERS	Provi der Hospi ce (	CCN: 151324 CCN: 151519	Period: From 01/01/2015 To 08/31/2015	Worksheet K-5 Part II Date/Time Pre 8/15/2016 3:5	pared:
					Hospi ce I		•
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG &	EMPLOYEE	Reconciliati	on ADMI NI STRATI VE	OPERATION OF	
		FIXT (SQUARE FEET)	BENEFITS DEPARTMENT (GROSS SALARIES)		& GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	
		1.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	249	103, 684		0 32, 941	249	1.00
2.00	Inpatient - General Care	0	C		0 0	0	2.00
3.00	Inpatient - Respite Care	0	C		0 0	0	3.00
4.00	Physician Services	0	C	)	0 0	0	4.00
5.00	Nursing Care	0	C		0 109, 701	0	5.00
6.00	Nursing Care-Continuous Home Care	0	C		0 0	0	6.00
7.00	Physical Therapy	0	C		0 0	0	7.00
8.00	Occupational Therapy	0	C		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0	C		0 0	0	9.00
10,00	Medical Social Services	0	C		0 150, 203	0	10.00
11.00	Spiritual Counseling	0	C		0 0	0	11.00
12.00	Dietary Counseling	0	C	)	0 0	0	12.00
13.00	Counseling - Other	0	C	)	0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	C		0 11, 521	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	C		0 0	0	15.00
16.00	Other	0	C	)	0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	C	)	0 0	0	17.00
18.00	Anal gesi cs	0	C	)	0 0	0	18.00
19.00	Sedatives / Hypnotics	0	C	)	0 0	0	19.00
20.00	Other - Specify	0	C	)	0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	C	)	0 0	0	21.00
22.00	Patient Transportation	0	C	)	0 0	0	22.00
23.00	Imaging Services	0	0	)	0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0	0	24.00
25.00	Medical Supplies	0	0		0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radiation Therapy	0	0		0 0	0	27.00
28.00	Chemotherapy	0	0		0 0	0	28.00
29.00	Other	0	0		0 0	0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0		0 0	0	31.00
32.00	Fundrai si ng	0	0	)	0 0	0	32.00
33.00	Other Program Costs	0	0	)	0 0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	249	103, 684		304, 366	249	34.00
35.00	Total cost to be allocated	4, 135	28, 806	,	60, 198	2, 405	35.00
36.00	Unit Cost Multiplier (see instructions)	16. 606426	0. 277825		0. 197782	9. 658635	36.00

STATI STI CAL BASI S Cost Center Description LAUNDRY & LI NEN SERVICE (DOLLAR VALUE) HOUSI (HO SERVICE	Provi der CCN: 151324 Hospi ce CCN: 151519 EKEEPI NG DI ETARY DURS OF (MEALS RVI CE) SERVED) 9. 00 10. 00 0 0	Hospi ce I CAFETERI A	Date/Time Prep 8/15/2016 3:50 NURSING ADMINISTRATION (MAN HOURS) 13.00	pared: 6 pm
Cost Center Description       LAUNDRY & LINEN SERVICE (DOLLAR VALUE)       HOUSI (HO SEI VALUE)         1.00       Administrative and General Inpatient - General Care       0	EKEEPING DURS OF RVICE) DI ETARY (MEALS SERVED) 9. 00 10. 00 0 0	Hospi ce I CAFETERI A (MAN HOURS) 11.00 0 00	8/15/2016 3: 50 NURSI NG ADMI NI STRATI ON (MAN HOURS) 13. 00	6 pm
1.00     Admini strative and General     0       2.00     Inpatient - General Care     0	OURS OF RVI CE)         (MEALS SERVED)           9.00         10.00           0         0	CAFETERI A (MAN HOURS) 11.00 0 0	ADMI NI STRATI ON (MAN HOURS) 13.00	
1.00     Admini strative and General     0       2.00     Inpatient - General Care     0	OURS OF RVI CE)         (MEALS SERVED)           9.00         10.00           0         0	(MAN HOURS) 11.00 0 0	ADMI NI STRATI ON (MAN HOURS) 13.00	
Image: Constraint of the second se	RVI CE) SERVED) 9.00 10.00 0 0 0	HOURS)	(MAN HOURS) 13.00	
VALUE)       1.00     Administrative and General     0       2.00     Inpatient - General Care     0	9.00 10.00 0 0	11.00 0 0	HOURS) 13.00	
1.00     Administrative and General     0       2.00     Inpatient - General Care     0	0 0	0 0	HOURS) 13.00	
1.00Administrative and General02.00Inpatient - General Care0	0 0	0 0	13.00	
1.00Administrative and General02.00Inpatient - General Care0	0 0	0 0		
	-	0 0		1.00
3.00 Inpatient - Respite Care 0	0		0	2.00
		0 0	0	3.00
4.00 Physician Services 0	0	0 0	0	4.00
5.00 Nursing Care 0	0	0 0	0	5.00
6.00 Nursing Care-Continuous Home Care 0	0	0 0	0	6.00
7.00 Physical Therapy 0	0	0 0	0	7.00
8.00 Occupational Therapy 0	0	0 0	0	8.00
9.00 Speech/ Language Pathol ogy 0	0	0 0	0	9.00
10.00 Medical Social Services 0	0	0 0	0	10.00
11.00 Spiritual Counseling 0	0	0 0	0	11.00
12.00 Dietary Counseling 0	0	0 0	0	12.00
13.00 Counseling - Other 0	0	0 0	0	13.00
14.00 Home Health Aide and Homemaker 0	0	0 0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care 0	0	0 0	0	15.00
16.00 Other 0	0	0 0		16.00
17.00 Drugs, Biological and Infusion Therapy 0	0	0 0		17.00
18.00 Anal gesi cs 0	0	0 0		18.00
19.00 Sedatives / Hypnotics 0	0	0 0		19.00
20.00 Other - Specify 0	0	0 0		20.00
21.00 Durable Medical Equipment/Oxygen 0	0	0 0		21.00
22.00 Patient Transportation 0	0	0 0		22.00
23.00 I magi ng Servi ces 0	0	0 0		23.00
24.00 Labs and Diagnostics 0	0	0 0		24.00
25.00 Medical Supplies 0	0	0 0		25.00
26.00 Outpatient Services (including E/R Dept.) 0	0	0 0	0	26.00
27.00 Radiation Therapy 0	0	0 0	0	27.00
28.00 Chemotherapy 0	0	0 0	0	28.00
29.00 Other 0	0	0 0	0	29.00
30.00 Bereavement Program Costs 0	0	0 0	0	30.00
31.00 Volunteer Program Costs 0	U U	0 0	0	31.00
32.00 Fundrai si ng 0	U U		0	32.00 33.00
33.00 Other Program Costs 0 34.00 Total (sum of lines 1 thru 33) (2) 0	0	0 0	0	33.00 34.00
34.00Total (sum of lines 1 thru 33) (2)035.00Total cost to be allocated0		0 0	0	34.00 35.00
36.00 Unit Cost Multiplier (see instructions) 0.000000	0. 000000 0. 0000	0		
	0.0000	0.00000	0.00000	30.00

ALLOCA	Financial Systems ATION OF GENERAL SERVICE COSTS TO HOSPICE COS	T CENTERS	Provi der	CCN: 151324	Peri od:	Worksheet K-	5
	STI CALI BASI S			CN: 151519	From 01/01/2015	Part II	epared:
					Hospi ce I	8/15/2010 3::	so pili
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
	•	SERVICES &	(100%	RECORDS &			
		SUPPLY	ALLOCATION)	LI BRARY	(TIME		
		(100%		(TIME	SPENT)		
		ALLOCATION)		SPENT)			
	1	14.00	15.00	16.00	17.00		
. 00	Administrative and General	0	0		0 0		1.0
2.00	Inpatient - General Care	0	0		0 0		2.0
3.00	Inpatient - Respite Care	0	0		0 0		3.0
1.00	Physi ci an Servi ces	0	0		0 0		4.0
5.00	Nursing Care	0	0		0 0		5.0
5.00	Nursing Care-Continuous Home Care	0	0		0 0		6.0
7.00	Physical Therapy	0	0		0 0		7.0
3.00	Occupational Therapy	0	0		0 0		8.0
9.00	Speech/ Language Pathol ogy	0	0		0 0		9.0
0.00	Medical Social Services	0	0		0 0		10.0
1.00	Spiritual Counseling	0	0		0 0		11.0
2.00	Di etary Counsel i ng	0	0		0 0		12.0
3.00	Counseling - Other	0	0		0 0		13.0
4.00	Home Health Aide and Homemaker	0	0		0 0		14.0
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0		15.0
6.00	Other	0	0		0 0		16.0
7.00	Drugs, Biological and Infusion Therapy	0	0		0 0		17.0
8.00	Anal gesi cs	0	0		0 0		18.0
9.00	Sedatives / Hypnotics	0	0		0 0		19.0
20.00	Other - Specify	0	0		0 0		20.0
21.00	Durable Medical Equipment/Oxygen	0	0		0 0		21.0
2.00	Patient Transportation	0	0		0 0		22.0
3.00	I maging Services	0	0		0 0		23.0
4.00	Labs and Diagnostics	0	0		0 0		24.0
5.00	Medical Supplies	0	0		0 0		25.0
6.00	Outpatient Services (including E/R Dept.)	0	0		0 0		26.0
7.00	Radiation Therapy	0	0		0 0		27.0
8.00	Chemotherapy	0	0		0 0		28.0
9.00	Other	0	0		0 0		29.0
0.00	Bereavement Program Costs	0	0		0 0		30.0
1. 00	Volunteer Program Costs	0	0		0 0		31.0
32.00	Fundrai si ng	0	0		0 0		32.0
33.00	Other Program Costs	0	0		0 0		33.0
34.00	Total (sum of lines 1 thru 33) (2)	0	0		0 0		34.0
35.00	Total cost to be allocated	0	0		0 0		35.0
36.00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0.0000	0. 000000		36.0

Heal th	Financial Systems	JASPER COUNTY HOSPIT	AL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF TOTAL HOSPICE SHARED COSTS	Pro	ovider C		Peri od:	Worksheet K-5	
					From 01/01/2015		
		HOS	spice cu	CN: 151519	To 08/31/2015	Date/Time Pre 8/15/2016 3:50	
					Hospi ce I	0/13/2010 3.3	o pii
	Cost Center Description	Wkst. C	Part C	Cost to Chard	e Total Hospice	Hospice Shared	
		I, col	. 11	Ratio	Charges	Áncillary	
		lin	e		(Provi der	Costs (cols. 1	
					Records)	x 2)	
		0		1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY		66.00	0. 82012	21 0	0	1.00
1.01	KV HEALTH PT		66.01	1. 16501	19 0	0	1.01
2.00	OCCUPATIONAL THERAPY		67.00	2.39156	52 0	0	2.00
2.01	KV HEALTH OT		67.01	1.87053	39 0	0	2.01
3.00	SPEECH PATHOLOGY		68.00	2. 32724	14 0	0	3.00
3.01	KV HEALTH ST		68.01	2.12956	53 0	0	3.01
4.00	DRUGS CHARGED TO PATIENTS		73.00	0. 42178	37 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00				5.00
6.00	LABORATORY		60.00	0. 28204	1 0	0	6.00
6.01	BLOOD LABORATORY		60.01	0.00000	0 0	0	6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00	0.40706	50 0	0	7.00
8.00	FAMILY PRACTICE		93.00	0.00000	0 0	0	8.00
9.00	RADI OLOGY-THERAPEUTI C		55.00				9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS		76.00				10.00
11.00	Totals (sum of lines 1-10)					0	11.00

Health Financial Systems JASPER COU	NTY HOSPI	TAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF HOSPICE PER DIEM COST	Pr	ovi der	CCN: 151324	Period:	Worksheet K-6	
	Ho	ospi ce C	CN: 151519	From 01/01/2015 To 08/31/2015	Date/Time Prep 8/15/2016 3:56	
				Hospi ce I		
	Title	XVIII	Title XIX	Other	Total	
	1.	00	2.00	3.00	4.00	
1.00 Total cost (see instructions)					366, 969	1.00
2.00 Total Unduplicated Days (Worksheet S-9, column 6, line 5)					2, 876	2.00
3.00 Average cost per diem (line 1 divided by line 2)					127.60	3.00
4.00 Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)		2, 324				4.00
5.00 Aggregate Medicare cost (line 3 time line 4)		296, 542				5.00
6.00 Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)				39		6.00
7.00 Aggregate Medicaid cost (line 3 time line 60)			4, 9	76		7.00
8.00 Upduplicated SNF Days (Worksheet S-9, column 3, line 5)		0				8.00
9.00 Aggregate SNF cost (line 3 time line 8)		0				9.00
10.00 Unduplicated NF Days (Worksheet S-9, column 4, line 5)				0		10.00
11.00 Aggregate NF cost (line 3 times line 10)				0		11.00
12.00 Other Unduplicated days (Worksheet S-9, column 5, line 5)				513		12.00
13.00 Aggregate cost for other days (line 3 times line 12)				65, 459		13.00

	Financial Systems	JASPER COUNT				u of Form CMS-	
	IS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDE	RALLY QUALIFIED	Provi der	CCN: 151324	Period: From 01/01/2015	Worksheet M-1	
HEALIH	CENTER COSTS		Component	CCN: 153990	To 08/31/2015	Date/Time Pre 8/15/2016 3:5	
					Rural Health Clinic (RHC) I	Cost	
		Compensati on	Other Costs	Total (col.	1 Recl assi fi cati	Reclassi fi ed	
				+ col. 2)	ons	Trial Balance	
				· · · ·		(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS				-		1
1.00	Physi ci an	0	0		0 0		
2.00	Physician Assistant	0	0		0 0	-	
3.00	Nurse Practitioner	78, 186	0	78, 1		78, 186	
4.00	Visiting Nurse	0	0		0 0	0	
5.00	Other Nurse	20, 519	0	20, 5		20, 519	
6.00	Clinical Psychologist	0	0		0 0	0	
7.00	Clinical Social Worker	0	0		0 0	0	7.00
8.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0		0 0	0	
10.00	Subtotal (sum of lines 1 through 9)	98, 705	0	98, 7	05 0	98, 705	10.00
11.00	Physician Services Under Agreement	0	34, 396	34, 3	96 0	34, 396	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	34, 396	34, 3	96 0	34, 396	14.00
15.00	Medical Supplies	0	16, 960	16, 9	60 0	16, 960	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs	0	0		0 0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	16, 960	16, 9	60 0	16, 960	21.00
22.00	Total Cost of Health Care Services (sum of	98, 705	51, 356	150, 0	61 0	150, 061	22.00
	lines 10, 14, and 21)						
	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	0	0		0 0	0	28.00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0		0 0		
30.00	Administrative Costs	22, 080	31, 761	53, 8	41 0	53, 841	30.00
31.00	Total Facility Overhead (sum of lines 29 and	22, 080	31, 761	53, 8	41 0	53, 841	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	120, 785	83, 117	203, 9	02 0	203, 902	32.00
	and 31)			1	1	1	1

	Financial Systems	JASPER COUNTY		CON 151004		u of Form CMS	
	IS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDEI CENTER COSTS	KALLY QUALIFIED	Provi der	CCN: 151324	Period: From 01/01/2015	Worksheet M-	1
ILALIN	CENTER COSTS		Component	CCN: 153990	To 08/31/2015	Date/Time Pr 8/15/2016 3:	
					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			
1.00	Physi ci an	0	0	•			1.0
2.00	Physician Assistant	0	0	•			2.0
3.00	Nurse Practitioner	0	78, 186				3.0
4.00	Visiting Nurse	0	0				4.0
5.00	Other Nurse	0	20, 519				5.0
5.00	Clinical Psychologist	0	0				6.0
7.00	Clinical Social Worker	0	0				7.0
3.00	Laboratory Techni ci an	0	0				8.0
9.00	Other Facility Health Care Staff Costs	0	0				9.0
0.00	Subtotal (sum of lines 1 through 9)	0	98, 705				10.0
1.00	Physician Services Under Agreement	0	34, 396	1			11.0
2.00	Physician Supervision Under Agreement	0	0				12.0
3.00	Other Costs Under Agreement	0	0 34, 396				13. C
14.00 15.00	Subtotal (sum of lines 11 through 13) Medical Supplies	0	34, 396 16, 960				14.0
16.00	Transportation (Health Care Staff)	0	10, 900	1			16.0
17.00	Depreciation-Medical Equipment	0	0				17.0
18.00	Professional Liability Insurance	0	0	•			18.0
19.00	Other Health Care Costs	0	0				19.0
20.00	Allowable GME Costs	0	0				20.0
21.00	Subtotal (sum of lines 15 through 20)	0	16, 960				21.0
22.00	Total Cost of Health Care Services (sum of	0	150, 061				22.0
	lines 10, 14, and 21)	-	,				
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0				23.0
24.00	Dental	0	0				24.0
25.00	Optometry	0	0				25.0
26.00	All other nonreimbursable costs	0	0				26.0
27.00	Nonallowable GME costs	0	0				27.0
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.0
	through 27)						_
	FACILITY OVERHEAD			1			
29.00	Facility Costs	0	0				29.0
30.00	Administrative Costs	-4, 280	49, 561				30.0
31.00	Total Facility Overhead (sum of lines 29 and	-4, 280	49, 561				31.0
22.00	30) Tatal facility anata (aum of lines 22, 20	4 200	100 (00				1 22 0
32.00	Total facility costs (sum of lines 22, 28 and 31)	-4, 280	199, 622				32.0

	Financial Systems	JASPER COUNT			In Lie	u of Form CMS-:	2552-10
	IS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDE	RALLY QUALIFIED	) Provi der	CCN: 151324	Peri od:	Worksheet M-1	
HEALTH	CENTER COSTS		Component	- CCN, 159502	From 01/01/2015	Data /Tima Dra	narod
			component	CCN: 158502	To 08/31/2015	Date/Time Pre 8/15/2016 3:5	
					Rural Health	Cost	
					Clinic (RHC) IV		
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati		
				+ col. 2)	ons	Trial Balance	
				· ·		(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS	r					
1.00	Physi ci an	0	0		0 0	-	1.00
2.00	Physician Assistant	0	0		0 0	0	2.00
3.00	Nurse Practitioner	69, 662	0	69, 6	62 0	69, 662	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	50, 834	0	50, 8	34 0	50, 834	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 Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0		0 0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	120, 496	0	120, 4	96 0	120, 496	10.00
11.00	Physician Services Under Agreement	0	34, 424	34, 4	24 0	34, 424	11.00
12.00	Physician Supervision Under Agreement	о	0		0 0	0	12.00
13.00	Other Costs Under Agreement	о	0		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	34, 424	34, 4	24 0	34, 424	14.00
15.00	Medical Supplies	0	17, 363	17, 3	63 0	17, 363	15.00
16.00	Transportation (Health Care Staff)	0	0		0 0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs	0	0		0 0	0	•
21.00	Subtotal (sum of lines 15 through 20)	0	17, 363	17, 3	63 0	17, 363	21.00
22.00	Total Cost of Health Care Services (sum of	120, 496	51, 787				•
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FOHC SERVICS						1
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	о	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	0	0		0 0	0	
	through 27)						
	FACILITY OVERHEAD						1
29.00	Facility Costs	0	0		0 0	0	29.00
30.00	Administrative Costs	26, 044	20, 689	46, 7	33 0	46, 733	30.00
31.00	Total Facility Overhead (sum of lines 29 and	26, 044	20, 689	46, 7	33 0	46, 733	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	146, 540	72, 476	219, 0	16 0	219, 016	32.00
	and 31)						

	Financial Systems	JASPER COUNTY		001 454004		u of Form CMS-	
	IS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDE	RALLY QUALIFIED	Provi der	CCN: 151324	Period: From 01/01/2015	Worksheet M-	1
HEALTH	CENTER COSTS		Componen	t CCN: 158502	To 08/31/2015	Date/Time Pro 8/15/2016 3:	
					Rural Health Clinic (RHC) IV	Cost	•
		Adjustments	Net Expenses				
		f	°or Allocation	1			
			(col. 5 + col.				
			6)	-			
		6.00	7.00				_
1 00	FACILITY HEALTH CARE STAFF COSTS	0					1 1 0
1.00	Physician	0	C				1.0
2.00	Physician Assistant	0	0				2.0
3.00	Nurse Practitioner	0	69, 662				3.0
4.00	Visiting Nurse	0	F0.024				4.0
5.00	Other Nurse	0	50, 834				5.0
6.00	Clinical Psychologist	0	C				6.0
7.00	Clinical Social Worker	0	C				7.0
8.00	Laboratory Technician	0	C				8.0
9.00	Other Facility Health Care Staff Costs	0	120 100				9.0
0.00	Subtotal (sum of lines 1 through 9)	0	120, 496	1			10.0
11.00	Physician Services Under Agreement	0	34, 424	1			11.0
12.00	Physician Supervision Under Agreement	0	C				12.0
13.00	Other Costs Under Agreement	0	C				13.0
14.00	Subtotal (sum of lines 11 through 13) Medical Supplies	0	34, 424	1			14.0
15.00 16.00	Transportation (Health Care Staff)	0	17, 363 C	1			16.0
17.00	Depreciation-Medical Equipment	0	C				17.0
18.00	Professional Liability Insurance	0	0	1			18.0
19.00	Other Health Care Costs	0	C				19.0
20.00	Allowable GME Costs	0	0	1			20.0
21.00	Subtotal (sum of lines 15 through 20)	0	17, 363				21.0
22.00	Total Cost of Health Care Services (sum of	0	172, 283	1			22.0
22.00	Lines 10, 14, and 21)	0	172,200				22.0
	COSTS OTHER THAN RHC/FQHC SERVICS			1			
23.00	Pharmacy	0	C				23.0
24.00	Dental	0	C	•			24.0
25.00	Optometry	o	C				25.0
26.00	All other nonreimbursable costs	o	C				26.0
27.00	Nonallowable GME costs	0	C	)			27.0
28.00	Total Nonreimbursable Costs (sum of lines 23	0	C				28.0
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	C				29.0
30.00	Administrative Costs	0	46, 733				30.0
31.00	Total Facility Overhead (sum of lines 29 and	0	46, 733				31.0
	30)						
32.00	Total facility costs (sum of lines 22, 28	0	219, 016	•			32.0
	and 31)						

	Financial Systems	JASPER COUNT						u of Form CMS-	
ALLOCA	ATION OF OVERHEAD TO RHC/FQHC SERVICES		Pro	ovi der	CCN: 151324	Peri od		Worksheet M-2	
			Con	nnonent	CCN: 153990		1/01/2015 8/31/2015		pared.
				iponone				8/15/2016 3:5	
							Heal th	Cost	
					<b>B</b> 1 1 1 1 1		<u>C (RHC) I</u>		
		Number of FTE Personnel	Total V	ISITS	Productivit Standard (1			Greater of col. 2 or col.	
		Personner			Stanuaru (1	) (COL.	3)	4	
		1.00	2.0	0	3.00		4.00	5.00	
	VISITS AND PRODUCTIVITY			<u> </u>	0100			0100	
	Posi ti ons								1
1.00	Physi ci an	0.00		0	4, 2	00	0		1.00
2.00	Physician Assistant	0.00		0	2, 1	00	0		2.00
3.00	Nurse Practitioner	0. 72		1, 887	2, 1	00	1, 512		3.00
4.00	Subtotal (sum of lines 1 through 3)	0. 72		1, 887			1, 512	1, 887	4.00
5.00	Visiting Nurse	0.00		0				0	5.00
6.00	Clinical Psychologist	0.00		0				0	
7.00	Clinical Social Worker	0.00		0				0	1 1.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00		0				0	1
7.02	Diabetes Self Management Training (FQHC	0.00		0				0	7.02
	onl y)								
8.00	Total FTEs and Visits (sum of lines 4	0. 72		1, 887				1, 887	8.00
0 00	through 7)								0.00
9.00	Physician Services Under Agreements			36				36	9.00
								1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	0 RHC/FOHC SERV	/LCES					1.00	
10.00	Total costs of health care services (from Wk			2)				150, 061	1 10. 00
11.00	Total nonreimbursable costs (from Wkst. M-1,							0	1
12.00	Cost of all services (excluding overhead) (s							150, 061	
13.00	Ratio of RHC/FQHC services (line 10 divided		,					1.000000	
14.00	Total facility overhead - (from Wkst. M-1, c		)					49, 561	14.00
15.00	Parent provider overhead allocated to facili							79, 676	•
16.00	Total overhead (sum of lines 14 and 15)	5.	,					129, 237	
17.00	Allowable GME overhead (see instructions)							0	17.00
18.00	Subtotal (see instructions)							129, 237	18.00
19.00	Overhead applicable to RHC/FQHC services (li	ne 13 x line 18	3)					129, 237	19.00
20.00	Total allowable cost of RHC/FQHC services (s	um of lipos 10	and $10$					279, 298	1 20 00

	Financial Systems	JASPER COUNT				eu of Form CMS-2	
ALLOCA	ATION OF OVERHEAD TO RHC/FQHC SERVICES		Provi der	CCN: 151324	Peri od:	Worksheet M-2	
			Componer	t CCN: 158502	From 01/01/2015 To 08/31/2015		pared <sup>.</sup>
			componio	000002		8/15/2016 3:5	
					Rural Health	Cost	
				1	Clinic (RHC) IV		
		Number of FTE	Total Visits		/ Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
		1.00	2.00	3.00	3)	5.00	
	VI SI TS AND PRODUCTI VI TY	1.00	2.00	3.00	4.00	5.00	
	Posi ti ons						1
1.00	Physi ci an	0.00		0 4, 20	0 0		1.00
2.00	Physician Assistant	0.00		2,10			2.00
3.00	Nurse Practitioner	0.67	2, 50	5 2, 10	1, 407		3.00
4.00	Subtotal (sum of lines 1 through 3)	0. 67	2, 50		1, 407	2, 505	4.00
5.00	Visiting Nurse	0.00		o		0	5.00
6.00	Clinical Psychologist	0.00		0		0	6.00
7.00	Clinical Social Worker	0.00		0		0	
7.01	Medical Nutrition Therapist (FQHC only)	0.00		0		0	7.01
7.02	Diabetes Self Management Training (FQHC	0.00		0		0	7.02
	only)						
8.00	Total FTEs and Visits (sum of lines 4	0. 67	2, 50	5		2, 505	8.00
9.00	through 7) Physician Services Under Agreements		48	2		483	9.00
9.00	Physician services under Agreements		48	3		483	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	) RHC/FOHC SERV	I CES			1100	
10.00	Total costs of health care services (from Wk					172, 283	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,					0	
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			172, 283	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, c					46, 733	14.00
15.00	Parent provider overhead allocated to facili	ty (see instruc	tions)			170, 381	
16.00	Total overhead (sum of lines 14 and 15)					217, 114	
17.00	Allowable GME overhead (see instructions)					0	
18.00	Subtotal (see instructions)	40 11 15				217, 114	
19.00	Overhead applicable to RHC/FQHC services (li					217, 114	
20.00	Total allowable cost of RHC/FQHC services (s	um of lines 10	and 19)			389, 397	20.00

	Financial Systems JASPER COUNTY I ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FOHC SERVICES	Provider CCN: 151324	Peri od:	u of Form CMS-2 Worksheet M-3	
ALCUL	ATTON OF REIMBORSEMENT SETTLEMENT FOR RHC/FUHC SERVICES	Provider CCN. 151324	From 01/01/2015	WOLKSHEEL M-3	
		Component CCN: 153990	To 08/31/2015	Date/Time Prep 8/15/2016 3:50	
		Title XVIII	Rural Health Clinic (RHC) l	Cost	•
				1.00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			1.00	
. 00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, li	ne 20)		279, 298	1.0
. 00	Cost of vaccines and their administration (from Wkst. M-4, li			61	2.0
. 00	Total allowable cost excluding vaccine (line 1 minus line 2)			279, 237	3.
. 00	Total Visits (from Wkst. M-2, column 5, line 8)			1, 887	4.
. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		36	5.
. 00	Total adjusted visits (line 4 plus line 5)			1, 923	6.
. 00	Adjusted cost per visit (line 3 divided by line 6)			145.21	7.
			Cal cul ati on	of Limit (1)	
			Prior to	On on After	
			January 1	January 1	
			1.00	2.00	
3.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	80.44	80.44	8.
. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		145. 21	145.21	9.
0. 00	Program covered visits excluding mental health services (from	contractor records)	0	128	10.
1.00	Program cost excluding costs for mental health services (line		0	18, 587	11.
2.00	Program covered visits for mental health services (from contra		0	0	12.
3.00	Program covered cost from mental health services (line 9 x li		0	0	13.
4.00	Limit adjustment for mental health services (see instructions	)	0	0	14.
5.00	Graduate Medical Education Pass Through Cost (see instruction	s)		0	15.
6.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			18, 587	
6. 01	Total program charges (see instructions)(from contractor's re			11, 020	
6. 02	Total program preventive charges (see instructions) (from prov			1, 220	
6.03	Total program preventive costs ((line 16.02/line 16.01) times			2, 058	
6. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		11, 446	16.
6. 05	Total program cost (see instructions)			13, 504	16.
7.00	Primary payer amounts			0	17.
8.00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		2, 221	18.
9.00	Beneficiary coinsurance for RHC/FQHC services (see instructio records)	ns) (from contractor		1, 516	19.
0. 00	Net Medicare cost excluding vaccines (see instructions)			13, 504	20.
1.00	Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		0	21.
2.00	Total reimbursable Program cost (line 20 plus line 21)			13, 504	
3.00	Allowable bad debts (see instructions)			0	23.
3. 01	Adjusted reimbursable bad debts (see instructions)			0	23.
4.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24.
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.
5.50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
6.00	Net reimbursable amount (see instructions)			13, 504	
26.01	Sequestration adjustment (see instructions)			270	
27.00	Interim payments			10, 157	
28.00 29.00	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 27,	and 29)		0 3, 077	28. 29.
29.00 30.00	Protested amounts (nonallowable cost report items) in accorda			3, 077	29. 30.
JU. UU	chapter I, §115.2	nce with two Pub. 15-11,		0	30.

	inancial Systems JASPER COUNTY			u of Form CMS-2	2552-1
CALCULAT	TION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provider CCN: 151324	Period: From 01/01/2015	Worksheet M-3	
		Component CCN: 158502		Date/Time Prep 8/15/2016 3:50	
		Title XVIII	Rural Health Clinic (RHC) IV	Cost	
				1.00	
	ETERMINATION OF RATE FOR RHC/FQHC SERVICES				
1.00 T	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, li	ne 20)		389, 397	1.0
	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		1, 010	2.0
	fotal allowable cost excluding vaccine (line 1 minus line 2)			388, 387	3.0
	Total Visits (from Wkst. M-2, column 5, line 8)			2, 505	4.C
	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		483	5.C
	Total adjusted visits (line 4 plus line 5)			2, 988	6.0
7.00 A	Adjusted cost per visit (line 3 divided by line 6)			129.98	7.0
			Cal cul ati on	OF LIMIT (I)	
			Prior to	On on After	
			January 1	January 1	
			1.00	2.00	
	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	80.44	80.44	8.0
	Rate for Program covered visits (see instructions)		129.98	129. 98	9.0
	ALCULATION OF SETTLEMENT			540	10.0
	Program covered visits excluding mental health services (from		0	519	10.0
	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr	2	0	67, 460 0	11. 0 12. 0
	Program covered cost from mental health services (line 9 x li		0	0	13.0
	imit adjustment for mental health services (see instructions		0	0	14.0
	Graduate Medical Education Pass Through Cost (see instruction		0	0	
	Fotal Program cost (sum of lines 11, 14, and 15, columns 1, 2			67, 460	
	Total program charges (see instructions)(from contractor's re			36, 400	
	Total program preventive charges (see instructions)(from prov			140	
16. 03 T	Total program preventive costs ((line 16.02/line 16.01) times	line 16)		259	16.0
	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		44, 440	16. C
16. 05 T	Fotal program cost (see instructions)			44, 699	16.0
17.00 P	Primary payer amounts			0	17.0
	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		11, 651	18.0
	Beneficiary coinsurance for RHC/FQHC services (see instructio records)	ns) (from contractor		4, 922	19. C
	let Medicare cost excluding vaccines (see instructions)			44, 699	20.0
	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		189	21. (
	fotal reimbursable Program cost (line 20 plus line 21)			44, 888	
	Allowable bad debts (see instructions)			0	23.0
	Adjusted reimbursable bad debts (see instructions)			0	23.0
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24.0 25.0
	)THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	c)		0	
	let reimbursable amount (see instructions)	3)		44, 888	
	Sequestration adjustment (see instructions)			44, 888	
	nterim payments			34, 855	
	Fentative settlement (for contractor use only)			0,000	28.0
	Balance due component/program (line 26 minus lines 26.01, 27,	and 28)		9, 135	29.0
	Protested amounts (nonallowable cost report items) in accorda			0	30.0
	chapter I, §115.2				

Heal th	Financial Systems JASPER COUNTY H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 151324	Peri od:	Worksheet M-4	
		Component CCN: 153990	From 01/01/2015 To 08/31/2015	Date/Time Pre 8/15/2016 3:50	
		Title XVIII	Rural Health Clinic (RHC) l	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		98, 705	98, 705	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota	I health care staff time	e 0. 000000	0.000154	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lin	0	15	3.00	
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr	0	18	4.00	
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	line 4)	0	33	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, lin	e 22)	150, 061	150, 061	6.00
7.00	Total overhead (from Wkst. M-2, line 16)		129, 237	129, 237	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tot divided by line 6)	0. 000000	0. 000220	8.00	
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	0	28	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	0	61	10. 00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	0	1	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10		0.00	61.00	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	0	0	13.00
	benefi ci ari es			_	
14.00	Program cost of pneumococcal and influenza vaccine and its (th (line 12 x line 13)	eir) administration	0	0	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (thei of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,		61	15.00	
16. 00	Total Program cost of pneumococcal and influenza vaccine and i administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	ts (their)		0	16. 00

Heal th	Financial Systems JASPER COUNTY H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST		Provider CCN: 151324	Peri od:	Worksheet M-4	
		Component CCN: 158502	From 01/01/2015 To 08/31/2015	Date/Time Prep 8/15/2016 3:50	
		Title XVIII	Rural Health Clinic (RHC) IV	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		120, 496	120, 496	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota	al health care staff time	e 0. 000492	0.000098	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lir		59	12	3.00
4.00			360	16	4.00
5.00			419	28	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, lir	ne 22)	172, 283	172, 283	6.00
7.00	Total overhead (from Wkst. M-2, line 16)		217, 114	217, 114	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tot divided by line 6)	al direct cost (line 5	0.002432	0. 000163	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	528	35	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)		947	63	10. 00
11.00		(from your records)	5	1	11.00
12.00			189.40	63.00	
13.00	Number of pneumococcal and influenza vaccine injections admini		107.40	00.00	
13.00	beneficiaries		'	0	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (th (line 12 x line 13)	neir) administration	189	0	14.00
15.00				1, 010	15.00
16. 00	Total Program cost of pneumococcal and influenza vaccine and i administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	ts (their)		189	16. 00
	1 1 10 Z 1 /		I		I

Heal th	Financial Systems JASPER COUNTY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVIC	ES Provider CCN: 151324	Period:	Worksheet M-5	
RENDER	ED TO PROGRAM BENEFICIARIES		From 01/01/2015 To 08/31/2015	Date/Time Prep 8/15/2016 3:50	
			Rural Health	Cost	
			Clinic (RHC) I	+ D	
			mm/dd/yyyy	t B Amount	
			1.00	2.00	
1.00	Total interim payments paid to provider		1.00	10, 157	1.00
2.00	Interim payments payable on individual bills, either submitte the contractor for services rendered in the cost reporting pe "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount b revision of the interim rate for the cost reporting period. A 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	Provider to Program			0	3.05
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	er to worksneet M-3, IIne		10, 157	4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk	review. Also show date of			5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		_		
5.01				0	5.01
5.02 5.03				0	5. 02 5. 03
5.05	Provider to Program			0	5.03
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 o	cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER			3, 077	6.01
6.02	SETTLEMENT TO PROGRAM			12 224	6. 02 7. 00
7.00	Total Medicare program liability (see instructions)		Contractor	13,234 NPR Date	7.00
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

Heal th	Financial Systems JASPER COUNTY HC	SPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR SERVICES Provider CCN: 151324		Peri od:	Worksheet M-5		
RENDER	ED TO PROGRAM BENEFICIARIES	Component CCN: 158502	From 01/01/2015 To 08/31/2015		
			Rural Health	8/15/2016 3:50 Cost	6 pm
			Clinic (RHC) IV		
				t B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to provider	· · · · · · · · · · · · · · · · · · ·		34, 855	1.00
2.00	Interim payments payable on individual bills, either submitted the contractor for services rendered in the cost reporting peri			0	2.00
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount bas revision of the interim rate for the cost reporting period. Als				3.00
	payment. If none, write "NONE" or enter a zero. (1)				
3.01	Program to Provider			0	3.01
3.01				0	3.01
3.02				0	3.02
3.03				0	3.04
3.04				0	3.05
0.00	Provider to Program				0.00
3.50				0	3.5
3.51				o	3.5
3.52				0	3.5
3.53				0	3.5
3.54				0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	3.9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer	to Worksheet M-3, line		34, 855	4.0
	27)				
	TO BE COMPLETED BY CONTRACTOR		-		
5.00	List separately each tentative settlement payment after desk re each payment. If none, write "NONE" or enter a zero. (1)	eview. Also show date o	f		5.0
F 01	Program to Provider				
5.01 5.02				0	5.01 5.02
5.02 5.03				0	5.0
5.05	Provider to Program			0	5.0
5.50				0	5.5
5.50				0	5.5
5.52				0	5.5
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.9
6.00	Determined net settlement amount (balance due) based on the cost report. (1)			-	6.0
5. 01	SETTLEMENT TO PROVIDER			9, 135	6.0
6. 02	SETTLEMENT TO PROGRAM			0	6.0
7.00	Total Medicare program liability (see instructions)			43, 990	7.00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00