	al Systems required by law (42 USC 1395 since the beginning of the co		to report can resul	t in all interim	of Form CMS-2552-10 FORM APPROVED OMB NO. 0938-0050
• •	OSPITAL HEALTH CARE COMPLEX C		Provider CCN: 151324	Period: From 01/01/2014 To 12/31/2014	Worksheet S
PART I - COST	REPORT STATUS				
Provider	1.[X] Electronically filed	cost report		Date: 12/21/20	015 Time: 2:10 pm
use only	2. [] Manually submitted co	st report			·
	3. [1] If this is an amended 4. [F] Medicare Utilization.			esubmitted this co	st report
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. [N] Initial Report for the second of the seco	11.c nis Provider CCN 12.[
					· ·

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 01/01/2014 and ending 12/31/2014 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 rapport were provided in compliance with such laws and regulations.

Encryption Information

f.ow0z0adR0FH4Vh

ECR: Date: 12/21/2015 Time: 2:10 pm ARNCa40plpSY:SX.BZ5MqQK:Zbvq70 pyL6r0gjs:pT3N.350zDwQGvAGYaLT b2Mi0gpy4v0iZT7U

PI: Date: 12/21/2015 Time: 2:10 pm eml:Krq.tdQstUnSdv.PJ:O1DeTG70 DMdO70XE01wt5DEW41Z6sKep9vP:vO

(Signed)

r or Administrator of Provider(s)

387,877

26,036 200.00

220,227

Date

Title XVIII Title V Part A Part B HIT Title XIX 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1.00 233,855 386,236 26.036 Hospital 1.00 Subprovider - IPF 2.00 0 2.00 3.00 Subprovider - IRF 0 0 3.00 0 0 0 0 0 0 4.00 SUBPROVIDER I 0 4.00 0 Swing bed - SNF Swing bed - NF 5.00 -13,6280 0 5.00 6.00 0 6.00 9.00 HOME HEALTH AGENCY I n n 0 9.00 10.00 RURAL HEALTH CLINIC I 0 650 0 10.00 RURAL HEALTH CLINIC IV 991 10.03 10.03 FEDERALLY QUALIFIED HEALTH CENTER I 11,00 11.00

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

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

Health Financial Systems JASPER COUNTY HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151324 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 12/21/2015 2:09 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1104 EAST GRACE STREET 1.00 PO Box: 1.00 State: IN Zip Code: 47978-2.00 City: RENSSELAER County: **JASPER** 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 JASPER COUNTY HOSPITAL 151324 99915 02/03/2005 Ν 0 0 3.00 Hospi tal Subprovider - IPF 4.00 4.00 5.00 Subprovider - IRF 5 00 Subprovi der - (Other) 6.00 6.00 7.00 Swing Beds - SNF JASPER COUNTY HOSPITAL 15Z324 99915 12/31/2005 N 0 N 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospital-Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 Hospi tal -Based HHA JASPER COUNTY HOSPITAL 12.00 157149 99915 05/13/1985 Ν Ρ Ν 12.00 13.00 Separately Certified ASC 13.00 JASPER COUNTY HOSPITAL 03/12/1993 14.00 Hospi tal -Based Hospi ce 151519 99915 14.00 15.00 Hospital-Based Health Clinic - RHC WHEATFIELD CLINIC 153990 99915 10/07/1999 Ν N 15.00 0 15.03 Hospital-Based Health Clinic - RHC BROOK 158502 99915 01/01/2005 Ν 0 Ν 15.03 16.00 Hospital-Based Health Clinic - FQHC 16.00 Hospital-Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2014 12/31/2014 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Ν Ν 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22 02 Is this a newly merged hospital that requires final uncompensated care payments to be N Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2, or after October 1. Did this hospital receive a geographic reclassification from urban to rural as a result Ν 22.03 Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no "N" <u>for no</u> In-State In-State Out-of Out-of Medi cai d Other Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days eligible unpai d paid days days unpai d 1.00 2.00 3. 00 4. 00 5. 00 6.00 24.00 | If this provider is an IPPS hospital, enter the 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 25 00 O 0 0 0 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)

Health Financial Systems JASPER COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151324 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 12/21/2015 2:09 pm Program Code Unweighted IME Program Name Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all

non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der	CCN: 15132	From O	: 1/01/2014 2/31/2014	Date/Time Pr	repared
						12/21/2015 2	2:09 pm
					1. 00	2. 00	
All Providers	66:+-		D. L. 15 1		NI.		
10.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	'N" for no in column 1	. If yes, and home umber. (see instruc	office co	sts	N		140. (
1.00 If this facility is part of a cha	in angonization anton	2.00	142 +l		3.00	of the	
home office and enter the home of				ie riallie arii	adul ess	or the	
1. 00 Name:	Contractor's Nam			actor's Nu	ımber:		141.
2. 00 Street: 3. 00 Ci ty:	PO Box: State:		Zip C	'odo			142. 143.
3. 00 C1 ty.	state.		ZIPC	oue.			143.
						1. 00	
4.00 Are provider based physicians' co	sts included in Worksh	neet A?				Y	144.
					1. 00	2.00	
5.00 If costs for renal services are c	aimed on Wkst. A, lin	ne 74, are the cost	s for		N	2.00	145.
inpatient services only? Enter "Y no, does the dialysis facility in	clude Medicare utiliza						
period? Enter "Y" for yes or "N" 6.00 Has the cost allocation methodolog		eviously filed cos	t renort?		N		146.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/g	n column 1. (See CMS P			lf	14		140.
						4.00	
7.00Was there a change in the statist	ical hasis? Enter "V"	for yes or "N" for	. no			1.00 N	147.
3.00 Was there a change in the order of						N	148.
0.00 Was there a change to the simplif	ed cost finding metho					N	149.
		Part A 1.00	Part 2.00		itle V 3.00	Title XIX 4.00	_
Does this facility contain a prov	ider that qualifies fo						
or charges? Enter "Y" for yes or						3. 13)	
5. 00 Hospi tal 5. 00 Subprovi der – TPF		N N	N N		N N	N N	155. 156.
7. 00 Subprovider - TRF		N	N N		N	N N	157.
3. 00 SUBPROVI DER							158.
9. 00 SNF		N	N N		N	N	159.
D.OO HOME HEALTH AGENCY 1.OO CMHC		N	N N		N N	N N	160. 161.
1. GO GWITC			I IV		IV	IV.	101.
Multicampus						1. 00	
5.00 s this hospital part of a Multical Enter "Y" for yes or "N" for no.	ampus hospital that ha	is one or more camp	uses in di	fferent CE	BSAs?	N	165.
, , , , , , , , , , , , , , , , , , , ,	Name	County	State		CBSA	FTE/Campus	
001f line 1/F is yes for each	0	1. 00	2. 00	3. 00	4. 00	5.00	201//
6.00 f line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. 0	00 166.
						1.00	
Health Information Technology (HI						1.50	
7.00 s this provider a meaningful use 3.00 f this provider is a CAH (line 10	r under §1886(n)? Ent O5 is "Y") and is a me	er "Y" for yes or eaningful user (lir	"N" for no).	the	Y	167. 0168.
reasonable cost incurred for the landistic and is reasonable cost incurred for the landistic and is reasonable.			er qualify	for a hard	ishi p		168.
exception under §413.70(a)(6)(ii) 9.00 If this provider is a meaningful	? Enter "Y" for yes or user (line 167 is "Y")	"N" for no. (see	instructio	ons)	•	0.0	00 169.
transition factor. (see instruction	ons)			Be	gi nni ng	Endi ng	
0.00 Enter in columns 1 and 2 the EHR					1. 00 /01/2014	2.00 12/31/2014	170.

Health Financial Systems	JASPER COUNTY HO	SPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 151324	From 01/01/2014	Worksheet S-2 Part I Date/Time Pre	
			12, 01, 2011	12/21/2015 2:	
				1.00	
171.00 If line 167 is "Y", does this provide	der have any days for individ	duals enrolled in sect	i on 1876	N	171. 00
Medicare cost plans reported on Wkst (see instructions)	t. S-3, Pt. I, line 2, col. 6	5? Enter "Y" for yes a	nd "N" for no.		

Health Financial Systems JASPER COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 151324 Peri od: Worksheet S-2 From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 12/21/2015 2:09 pm Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21 00 21.00 Was the cost report prepared only using the Ν N provider's records? If yes, see . instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If yes, see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору. Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Υ 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 30.00 Ν instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual Υ 32.00 arrangements with suppliers of services? If yes, see instructions.

If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provi der-Based Physi ci ans

Home Office Costs				
6.00 Were home office costs claimed on the cost report?		N		3
7.00 If line 36 is yes, has a home office cost statement been p	repared by the home office?	N		3
If yes, see instructions.				
8.00 If line 36 is yes , was the fiscal year end of the home of		N		3
the provider? If yes, enter in column 2 the fiscal year er				
9.00 If line 36 is yes, did the provider render services to oth	er chain components? If yes,	N		3
see instructions.				
0.00 If line 36 is yes, did the provider render services to the	home office? If yes, see	N		4
i nstructi ons.			L	┷
				4
	1.00	2.	00	
Cost Report Preparer Contact Information				
1.00 Enter the first name, last name and the title/position	KYLE	SMI TH		4
held by the cost report preparer in columns 1, 2, and 3,				
respecti vel y.				
2.00 Enter the employer/company name of the cost report	BLUE & CO			4
preparer.				
3.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957	KCSMI TH@BLUEANI	DCO. COM	4

N

Ν

Date

2.00

1.00

34.00

35.00

Are services furnished at the provider facility under an arrangement with provider-based physicians?

Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based

physicians during the cost reporting period? If yes, see instructions.

If yes, see instructions.

позетт	AL AND HUSPITAL HEALTH CARE REIMBURSEMENT QUE.	STI UNIVALKE	Provider CCN. 151324	From 01/01/2014 To 12/31/2014	Part II Date/Time Prepa 12/21/2015 2:09	
		Part B				
		Date				
		4. 00				
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)					16. 00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	05/02/2014				17. 00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					18. 00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.					19. 00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:					20. 00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.				:	21. 00
			3.00			
	Cost Report Preparer Contact Information		5. 55			
	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		ANAGER			41. 00
42. 00	Enter the employer/company name of the cost r preparer.	report				42. 00
43. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv					43. 00

Health Financial Systems JASPER HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

					To	12/31/2014	Date/Time Prep 12/21/2015 2:0	
							I/P Days / 0/P	J7 DIII
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	35p3.112	Line Number		o. Bous	Avai I abl e	57.11 1.15 d.1 5		
		1.00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		21	7, 665	75, 360. 00		1. 00
	8 exclude Swing Bed, Observation Bed and				,	.,		
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			21	7, 665	75, 360. 00	0	7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		4	1, 460	12, 312. 00	0	8.00
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	13.00
14.00	Total (see instructions)			25	9, 125	87, 672. 00	0	14.00
15.00	CAH visits						0	15.00
16.00	SUBPROVI DER - I PF							16.00
17. 00	SUBPROVI DER - I RF	41. 00		0	0		0	17.00
18.00	SUBPROVI DER	42. 00		0	0		0	18.00
19. 00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23.00
24.00	HOSPI CE	116. 00		0	0			24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25.00
26. 00	RURAL HEALTH CLINIC	88. 00					0	26.00
26. 03	RURAL HEALTH CLINIC IV	88. 03					0	26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			25				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00

| Peri od: | Worksheet S-3 | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: Provider CCN: 151324

				Т	o 12/31/2014	Date/Time Pre 12/21/2015 2:	
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7.00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	2, 136	225	3, 112			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	145	73				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	1, 006	0	1, 006			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	83			6. 00
7.00	Total Adults and Peds. (exclude observation	3, 142	225	4, 201			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	360	0	510			8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		0	66			13. 00
14.00	Total (see instructions)	3, 502	225	4, 777	0.00	291. 11	
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	0	0	0	0.00	0.00	17. 00
18. 00	SUBPROVI DER	0	0	0	0.00	0.00	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	8, 942	4, 210	17, 114	0.00	27. 21	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	4, 233	48	5, 314	0.00	2. 46	24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	216	344	3, 404	0.00	3. 62	26. 00
26. 03	RURAL HEALTH CLINIC IV	737	619	4, 995	0.00	3. 71	26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	328. 11	27. 00
28. 00	Observation Bed Days		0	1, 446			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			36			30.00
31. 00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	0	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33. 00

 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 151324
 Period: From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

				To	12/31/2014	Date/Time Pre 12/21/2015 2:0	
		Full Time		Di scha	arges		
		Equi val ents					
	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		0	600	65	951	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			36	38		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	0	600	65	951	14.00
15.00	CAH visits						15.00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	0. 00	0	0	0	0	17. 00
18.00	SUBPROVI DER	0. 00	0	0	0	0	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 03	RURAL HEALTH CLINIC IV	0. 00					26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00

	Financial Systems	JASPER COUNT		0011 454004 5		eu of Form CMS-2	
HOME F	HEALTH AGENCY STATISTICAL DATA				eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-4 Date/Time Prep	
-			Componen	1 0011. 137147	Home Health	12/21/2015 2: 0 PPS	
					Agency I	113	
					1.	00	
0. 00	County	Title V	Title XVIII	Title XIX	Other	Total	0. 00
		1.00	2. 00	3.00	4. 00	5. 00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	l c	0	0	0	1. 00
2.00	Unduplicated Census Count (see instructions)	0.00	240.00	0.00	0.00		2. 00
				Number of Empi	oyees (Full Ti	me Equivalent)	
			er of hours in	Staff	Contract	Total	
		your normal	l work week				
		(0	1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		0.00	0.00	0.00	0.00	3. 00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			0.00			5. 00 6. 00
7.00	Nursi ng Supervi sor			0.00	0.00	0.00	7. 00
8. 00 9. 00	Physical Therapy Service Physical Therapy Supervisor			0. 00 0. 00			8. 00 9. 00
10.00	Occupational Therapy Service			0.00			
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0.00			
13. 00	Speech Pathology Supervisor			0.00			
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0. 00 0. 00			
16. 00	Home Health Aide			0.00	0.00	0.00	16. 00
17. 00 18. 00	Home Health Aide Supervisor Other (specify)			0. 00 0. 00			
	HOME HEALTH AGENCY CBSA CODES				0.00	0.00	
19. 00	Enter in column 1 the number of CBSAs where you provided services during the cost			4			19. 00
20. 00	reporting period. List those CBSA code(s) in column 1 serviced			23844			20. 00
20.00	during this cost reporting period (line 20			23044			20.00
20. 01	contains the first code).			28100			20. 01
20. 02				29140 99915			20. 02
20. 03		Full E	pi sodes	99915			20. 03
		Without Outliers	With Outliers	LUPA Epi sodes	PEP Only Episodes	Total (cols. 1-4)	
	DDC ACTIVITY DATA	1. 00	2. 00	3.00	4. 00	5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	2, 430	568	101	45	3, 144	21. 00
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	293, 533 1, 792					22. 00 23. 00
24. 00	Physical Therapy Visits Physical Therapy Visit Charges	251, 424	l .	1			
25. 00	Occupational Therapy Visits	436	l .	l e	0		25. 00
26. 00 27. 00	Occupational Therapy Visit Charges Speech Pathology Visits	62, 208 133				139	26. 00 27. 00
28. 00	Speech Pathology Visit Charges	20, 305					
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	14 2, 898	l .	0 0			30.00
31.00	Home Health Aide Visits	1, 834			40		31.00
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	113, 904 6, 639					32. 00 33. 00
34. 00	29, and 31) Other Charges			0	0	0	34. 00
35. 00	Total Charges (sum of lines 22, 24, 26, 28,	744, 272	_	1		941, 625	
36. 00	30, 32, and 34) Total Number of Episodes (standard/non	292		31	7	330	36. 00
37. 00	outlier) Total Number of Outlier Episodes		23		0	23	37. 00
38. 00	Total Non-Routine Medical Supply Charges	11, 575	22, 364	146	9	34, 094	38. 00

STATI	TAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	IED HEALTH CENTER	Provi der	CCN: 151324	Peri od:	Worksheet S-8	
	STICAL DATA		Component	CCN: 153990	From 01/01/2014 To 12/31/2014		
					Rural Health Clinic (RHC) I	Cost	
					1.	00	
	Clinic Address and Identification				<u> </u>		
. 00	Street				492 S BIERMA S		1.
			Ci		State	ZIP Code	
	City Ctata 7LD Code County	WILE	1.	00	2. 00	3. 00 47978	2
2. 00	City, State, ZIP Code, County	WHE	ATFI ELD		I IV	47978	2.
-00	FOLICE ONLY Decimands on Fators IIDII for asserting					1.00	2
. 00	FQHCs ONLY: Designation - Enter "R" for rural	or "U" for urban			Grant Award	Date 0	3. (
					1. 00	2. 00	
	Source of Federal Funds				1.00	2.00	
4. 00	Community Health Center (Section 330(d), PHS	Act)			0		4. (
5. 00	Migrant Health Center (Section 329(d), PHS Ad				0		5. (
5. 00	Health Services for the Homeless (Section 340				0		6. (
7. 00	Appalachian Regional Commission				0		7.
3. 00	Look-Alikes				0		8.
. 00	OTHER (SPECIFY)				0		9.
0.01					0		9.
. 02					0		9.
. 03					0		9. 9.
. 05					0		9.
. 06					0		9.
. 07					0		9.
. 08					0		9. (
9. 09					0		9. (
9. 10					0		9. 1
					1. 00	2.00	
				s or "N" for	NI NI		
10.00	3 1				N	0	10. (
10. 00	no in column 1. If yes, indicate number of o	ther operations in	column 2. (Enter in	N	0	10. (
10. 00		ther operations in ation(s) and the o	column 2.(perating ho	Enter in urs.)		_	10. (
10. 00	no in column 1. If yes, indicate number of o	ther operations in ation(s) and the o Sunday	column 2.(perating ho	Enter in urs.) M	onday	Tuesday	10. 0
0. 00	no in column 1. If yes, indicate number of o	ther operations in ation(s) and the o Sunday from	column 2.(perating ho	Enter in urs.) M	onday to	Tuesday from	10. (
0.00	no in column 1. If yes, indicate number of or subscripts of line 11 the type of other opera	ther operations in ation(s) and the o Sunday	column 2.(perating ho	Enter in urs.) M	onday	Tuesday	10. (
	no in column 1. If yes, indicate number of o	ther operations in ation(s) and the o Sunday from	column 2.(perating ho to 2.00	Enter in urs.) M	onday to	Tuesday from	
	no in column 1. If yes, indicate number of or subscripts of line 11 the type of other operations (1)	ther operations in ation(s) and the o Sunday from	column 2.(perating ho to 2.00	Enter in urs.) M from 3.00	onday to 4.00	Tuesday from 5.00	
11. 00	no in column 1. If yes, indicate number of or subscripts of line 11 the type of other operations (1) Facility hours of operations (1) Clinic	ther operations in ation(s) and the o Sunday from 1.00	column 2.(perating ho to 2.00	Enter in urs.) M from 3.00	onday to 4.00 17:00 1.00	Tuesday from 5.00	11. (
11. 00	no in column 1. If yes, indicate number of or subscripts of line 11 the type of other operations (1) Facility hours of operations (1) Clinic Have you received an approval for an exception	ther operations in ation(s) and the organization Sunday from 1.00	column 2.(perating hoto 2.00	Enter in urs.) M from 3.00 08:00	onday to 4.00 17:00 1.00 N	Tuesday from 5.00	11. (
11. 00	no in column 1. If yes, indicate number of or subscripts of line 11 the type of other operations (1) Facility hours of operations (1) Clinic Have you received an approval for an exception is this a consolidated cost report as defined	ther operations in ation(s) and the of Sunday from 1.00	column 2.(perating ho to 2.00 vity standa 04, chapter	Enter in urs.) M from 3.00 08:00 rd? 9, section	onday to 4.00 17:00 1.00	Tuesday from 5.00	11. (
11. 00	ro in column 1. If yes, indicate number of or subscripts of line 11 the type of other operations (1) Facility hours of operations (1) Clinic Have you received an approval for an exception list his a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column list his according to the subscript of the	ther operations in ation(s) and the organization Sunday from 1.00	column 2.(perating ho to 2.00 vity standa 04, chapter er in colum	Enter in urs.) M from 3.00 08:00 rd? 9, section n 2 the	onday to 4.00 17:00 1.00 N	Tuesday from 5.00	11. (
1.00	Facility hours of operations (1) Clinic Have you received an approval for an exception list this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	ther operations in ation(s) and the organization Sunday from 1.00	column 2.(perating ho to 2.00 vity standa 04, chapter er in colum	Enter in urs.) M from 3.00 08:00 rd? 9, section n 2 the	onday to 4.00 17:00 1.00 N	Tuesday from 5.00	11. (
11. 00	ro in column 1. If yes, indicate number of or subscripts of line 11 the type of other operations (1) Facility hours of operations (1) Clinic Have you received an approval for an exception list his a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column list his according to the subscript of the	ther operations in ation(s) and the organization Sunday from 1.00	column 2.(perating ho to 2.00 vity standa 04, chapter er in colum	Enter in urs.) M from 3.00 08:00 rd? 9, section n 2 the eers and	onday to 4.00	Tuesday from 5.00 08:00 2.00	11. (
1.00	Facility hours of operations (1) Clinic Have you received an approval for an exception list this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	ther operations in ation(s) and the organization Sunday from 1.00	column 2.(perating ho to 2.00 vity standa 04, chapter er in colum	Enter in urs.) M from 3.00 08:00 rd? 9, section n 2 the ers and Provi	onday to 4.00 17:00 1.00 N	Tuesday from 5.00	11. (
1. 00 2. 00 3. 00	Facility hours of operations (1) Clinic Have you received an approval for an exception list this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	ther operations in ation(s) and the organization Sunday from 1.00	column 2.(perating ho to 2.00 vity standa 04, chapter er in colum	Enter in urs.) M from 3.00 08:00 rd? 9, section n 2 the ers and Provi	onday to 4.00 17:00 1.00 N N der name	Tuesday from 5.00 08:00 2.00 0 CCN number	11. (
1. 00 2. 00 3. 00	Facility hours of operations (1) Clinic Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	ther operations in ation(s) and the organization Sunday from 1.00	column 2.(perating ho to 2.00 vity standa 04, chapter er in colum	Enter in urs.) M from 3.00 08:00 rd? 9, section n 2 the ers and Provi	onday to 4.00 17:00 1.00 N N der name 1.00 XIX	Tuesday	12. (
12.00	Facility hours of operations (1) Clinic Have you received an approval for an exception list this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	ther operations in ation(s) and the o Sunday from 1.00	column 2.(perating ho to 2.00 vity standa 04, chapter er in colum	Enter in urs.) M from 3.00 08:00 rd? 9, section n 2 the ers and Provi	17: 00 1. 00 N N der name 1. 00	Tuesday from 5.00 08:00 2.00 CCN number 2.00	12. (13. (14. (14. (14. (14. (14. (14. (14. (14
11. 00 12. 00 13. 00	Facility hours of operations (1) Clinic Have you received an approval for an exception list this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all	ther operations in ation(s) and the organization Sunday from 1.00	column 2.(perating ho to 2.00 vity standa 04, chapter er in colum	Enter in urs.) M from 3.00 08:00 rd? 9, section n 2 the ers and Provi	onday to 4.00 17:00 1.00 N N der name 1.00 XIX	Tuesday	12. (
12. 00 13. 00	Facility hours of operations (1) Clinic Have you received an approval for an exception list this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	ther operations in ation(s) and the of Sunday from 1.00	column 2.(perating ho to 2.00 vity standa 04, chapter er in colum	Enter in urs.) M from 3.00 08:00 rd? 9, section n 2 the ers and Provi	onday to 4.00 17:00 1.00 N N der name 1.00 XIX	Tuesday	12. (13. (14. (14. (14. (14. (14. (14. (14. (14
11. 00 12. 00 13. 00	no in column 1. If yes, indicate number of or subscripts of line 11 the type of other operations of line 12 this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columnmber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	ther operations in ation(s) and the of Sunday from 1.00	column 2.(perating ho to 2.00 vity standa 04, chapter er in colum	Enter in urs.) M from 3.00 08:00 rd? 9, section n 2 the ers and Provi	onday to 4.00 17:00 1.00 N N der name 1.00 XIX	Tuesday	12. 13. 14.
11. 00 12. 00 13. 00	Facility hours of operations (1) Clinic Have you received an approval for an exception of subscripts a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all CME 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	ther operations in ation(s) and the of Sunday from 1.00	column 2.(perating ho to 2.00 vity standa 04, chapter er in colum	Enter in urs.) M from 3.00 08:00 rd? 9, section n 2 the ers and Provi	onday to 4.00 17:00 1.00 N N der name 1.00 XIX	Tuesday	12. (13. (14. (14. (14. (14. (14. (14. (14. (14
11. 00 12. 00 13. 00	Facility hours of operations (1) Clinic Have you received an approval for an exception of subscripts a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	ther operations in ation(s) and the of Sunday from 1.00	column 2.(perating ho to 2.00 vity standa 04, chapter er in colum	Enter in urs.) M from 3.00 08:00 rd? 9, section n 2 the ers and Provi	onday to 4.00 17:00 1.00 N N der name 1.00 XIX	Tuesday	12. (13. (14. (14. (14. (14. (14. (14. (14. (14
12.00	Facility hours of operations (1) Clinic Have you received an approval for an exception of subscripts a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. Provider name, CCN number Have you provided all or substantially all CME 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	ther operations in ation(s) and the of Sunday from 1.00	column 2.(perating ho to 2.00 vity standa 04, chapter er in colum	Enter in urs.) M from 3.00 08:00 rd? 9, section n 2 the ers and Provi	onday to 4.00 17:00 1.00 N N der name 1.00 XIX	Tuesday	12. (13. (14. (14. (14. (14. (14. (14. (14. (14

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	TED HEALTH CEN	TER Provider		Peri od:	Worksheet S-8	
STATISTICAL DATA		Component	CCN: 153990	From 01/01/2014 To 12/31/2014		pared: 09 pm_
				Rural Health	Cost	
				Clinic (RHC) I		
		Cou	ınty			
		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

	TAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	ED HEALTH CENTER	Provi der	CCN: 151324	Peri od:	Worksheet S-8	3
STATI	STICAL DATA		Component	CCN: 158502	From 01/01/2014 To 12/31/2014	12/21/2015 2:	
					Rural Health Clinic (RHC) IV		
					1.	00	
00	Clinic Address and Identification				420 F MALN CT		1 1
. 00	Street		Ci	tv	420 E MAIN ST State	7LP Code	1. (
			1. (2.00	3. 00	
. 00	City, State, ZIP Code, County	BROO)K		IN	47922	2.
						1.00	
. 00	FQHCs ONLY: Designation - Enter "R" for rural	or "U" for urban			C		3.
					Grant Award 1.00		
	Source of Federal Funds				1.00	2.00	
. 00	Community Health Center (Section 330(d), PHS	Act)			0		4.
. 00	Migrant Health Center (Section 329(d), PHS Ac				-	•	5.
. 00	Heal th Services for the Homeless (Section 340	O(d), PHS Act)			-		6.
. 00	Appal achi an Regional Commission						7.
00	Look-Alikes OTHER (SPECIFY)						8.
01	OTHER (SPECIFT)						9.
02							9.
03					0		9.
04					0		9.
05					0		9.
. 06					0		9.
. 07					0		9.
. 08					-		9.
. 09 . 10					0		9. 9.
. 10							7.
		501100 F 1	"\" 6		1. 00	2. 00	10
0. 00	Does this facility operate as other than an Fino in column 1. If yes, indicate number of otsubscripts of line 11 the type of other operations.	her operations in	col umn 2. (Enter in	N	0	10.
		Sunday	,,		londay	Tuesday	
		from	to	from	to	from	
	Facility hours of anomations (1)	1. 00	2.00	3. 00	4. 00	5. 00	
1. 00	Facility hours of operations (1) Clinic			08: 00	17: 00	Date/Time Pre	11.
		<u>'</u>					
2 00	Have you received an approval for an exception	un to the producti	i tu etende	ndO	1. 00 N	2.00	12.
2.00	1 3	'	,		N N	0	
3. 00	30. 8? Enter "Y" for yes or "N" for no in colu				14		15.
	number of providers included in this report.						
	numbers below.			Provi	der name	CCN number	
					1. 00		
	Provider name, CCN number						14.
4. 00		Y/N	V	XVIII	XIX		
4. 00			2. 00	3. 00	4. 00	5.00	15.
		1.00					
	GME cost? Enter "Y" for yes or "N" for no in	1.00					
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	1.00					
	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	1.00					
14.00	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	1.00					
	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	1.00					

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-	2552-10	
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	TED HEALTH CEN	TER Provider		Peri od:	Worksheet S-8		
STATISTICAL DATA		Component	CCN: 158502	From 01/01/2014 To 12/31/2014		pared: 09 pm	
				Rural Health	Cost		
				Clinic (RHC) IV			
		Cou	ınty				
		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	Sat	turday			
	from	to	from	to			
	11. 00	12.00	13. 00	14. 00			
Facility hours of operations (1)							
11. 00 Clinic	08: 00	17: 00				11. 00	

Health Financial Systems		JASPER COUNT	TY HOS	PI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL IDENTIFICATION DATA				Provi der	CCN: 151324	Peri od:	Worksheet S-9	
						From 01/01/2014	Parts I & II	
				Component	t CCN: 151519	To 12/31/2014	Date/Time Pre	pared:
				·			12/21/2015 2:	09 pm
						Hospi ce I		
	Unduplicated							
	Days							
	Title XVIII	Title XIX	Ti t	le XVIII	Title XIX	All Other	Total (sum of	
			S	killed	Nursi ng		cols. 1, 2 &	

						110001 00 1		
		Unduplicated Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		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	4, 193	48	0	0	1, 024	5, 265	2.00
3.00	Inpatient Respite Care	31	0	0	0	6	37	3.00
4.00	General Inpatient Care	9	0	0	0	2	11	4.00
5.00	Total Hospice Days	4, 233	48	0	0	1, 032	5, 313	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	83	3	0	0	24	110	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	51. 00	16. 00	0. 00	0. 00	43. 00	48. 30	8. 00
	5/line 6)							
9.00	Unduplicated Census Count	83	3	0	0	9	95	9. 00

	Financial Systems JASPER COUNTY	/ HOSPITAL		In Lie	u of Form CMS-2	2552-10				
HOSPI 7	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 151324	Peri od:	Worksheet S-10	0				
				From 01/01/2014 To 12/31/2014	Date/Time Prep 12/21/2015 2:0					
					1. 00					
	Uncompensated and indigent care cost computation									
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3	divided by li	ne 202 columi	າ 8)	0. 659056	1.00				
	Medicaid (see instructions for each line)									
2.00	Net revenue from Medicaid				1, 924, 947	2. 00				
3.00	Did you receive DSH or supplemental payments from Medicaid?			10	Y	3.00				
4.00	If line 3 is "yes", does line 2 include all DSH or supplement		from Medicaio	d'?	N 220, 210	4. 00				
5. 00 6. 00	If line 4 is "no", then enter DSH or supplemental payments 1 Medicaid charges		-329, 310 4, 409, 685							
7.00	Medicaid cost (line 1 times line 6)				2, 906, 229					
8.00	Difference between net revenue and costs for Medicaid progra	am (line 7 min	us sum of liu	nes 2 and 5: if	1, 310, 592					
0.00	<pre>< zero then enter zero) State Children's Health Insurance Program (SCHIP) (see instr</pre>			les 2 and 3, 11	1, 310, 372	0.00				
9. 00	Net revenue from stand-alone SCHIP	uctions for ea	acii i i ile)		0	9.00				
10.00					0					
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0					
12. 00	Difference between net revenue and costs for stand-alone SCH	HIP (line 11 m	inus line 9;	if < zero then	0					
	enter zero)	`								
	Other state or local government indigent care program (see i	nstructions fo	or each line))						
13.00	Net revenue from state or local indigent care program (Not i				0					
14. 00	Charges for patients covered under state or local indigent (10)	care program (Not included	in lines 6 or	0	14. 00				
15.00	State or local indigent care program cost (line 1 times line	,			0	15. 00				
16. 00	Difference between net revenue and costs for state or local 13; if < zero then enter zero)	indigent care	program (li	ne 15 minus line	0	16. 00				
	Uncompensated care (see instructions for each line)									
17. 00	Private grants, donations, or endowment income restricted to				0					
18.00	Government grants, appropriations or transfers for support			(()	0					
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and I 8, 12 and 16)	local Indigent		`	1, 310, 592	19. 00				
			Uni nsured	Insured	Total (col. 1					
			pati ents	pati ents	+ col . 2)					
20. 00	Total initial obligation of patients approved for charity ca	are (at full	1. 00 130, 9	2. 00	3. 00 130, 910	20. 00				
20.00	charges excluding non-reimbursable cost centers) for the entire cost centers approved for the entire cost centers.		130, 9	10	130, 910	20.00				
21. 00	Cost of initial obligation of patients approved for charity		86, 2	77 0	86, 277	21. 00				
22. 00	times line 20) Partial payment by patients approved for charity care			0 0	0	22. 00				
23. 00	Cost of charity care (line 21 minus line 22)		86, 2		86, 277					
23.00	cost of charity care (fine 21 minus fine 22)		00, 2	771 0		23.00				
24 00	Door the emount in line 20 celum 2 include them.	lont dou- l	nd o ltl	of atou !!=!+	1. 00	24.00				
24. 00	Does the amount in line 20 column 2 include charges for pati imposed on patients covered by Medicaid or other indigent ca		nu a rength o	oi stay ilmit	N	24. 00				
25. 00			ogram's Leng	th of stav limit	0	25. 00				
26. 00			ogram 3 reng	cii or stay rillii t	4, 835, 816					
27. 00										
			s line 27)		· ·					
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27) 4,717,562 28.									
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt	expense (line	1 times line	e 28)	3, 109, 138	29. 00				
		expense (line	1 times line	e 28)	3, 109, 138 3, 195, 415					

	Financial Systems	JASPER COUNTY		000 454004		u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der	1	Period: From 01/01/2014 Fo 12/31/2014	Worksheet A Date/Time Pre 12/21/2015 2:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	07 piii
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT		2, 033, 254			2, 103, 485	1.00
4. 00 5. 00	OO400	0 2, 434, 766	3, 987, 058 3, 814, 197	3, 987, 058 6, 248, 963		3, 987, 058 6, 129, 293	4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	2, 434, 766	3, 814, 197 812, 980			1, 060, 766	
8. 00	00800 LAUNDRY & LINEN SERVICE	71, 358	38, 046			109, 404	
9. 00	00900 HOUSEKEEPI NG	373, 471	88, 720	462, 19°		462, 191	
10.00	01000 DI ETARY	332, 420	225, 625	558, 04!	-172, 950	385, 095	10.00
11. 00	01100 CAFETERI A	0	0	(172, 950		
13.00	01300 NURSI NG ADMI NI STRATI ON	148, 350	968	149, 318		149, 318	
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	19, 463 401, 432	11, 683 1, 854, 113	31, 146 2, 255, 54!		31, 146 2, 255, 545	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	339, 745	44, 396			384, 141	1
17. 00	01700 SOCIAL SERVICE	0	37	3			1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	1, 697, 839	154, 829				1
31.00	03100 I NTENSI VE CARE UNI T	670, 518	28, 165	698, 683	-5, 866	692, 817	1
41. 00 42. 00	04100 SUBPROVI DER		0			0	41. 00 42. 00
	04300 NURSERY	0	0		132, 342	Ĭ	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	625, 931	2, 085, 948	2, 711, 87	-249	2, 711, 630	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(13, 234	13, 234	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 013, 779	1, 779, 317	2, 793, 096	-45, 411	2, 747, 685	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0	57. 00 58. 00
59. 00	05900 CARDIAC CATHETERIZATION		0			0	59.00
60.00	06000 LABORATORY	732, 985	1, 010, 117	1, 743, 102	2 0	1, 743, 102	
60. 01	06001 BLOOD LABORATORY	0	0	,	0	0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	83, 979	83, 979		83, 979	
65. 00	06500 RESPIRATORY THERAPY	864, 490	175, 434				
66. 00 66. 01	06600 PHYSI CAL THERAPY 06601 KV HEALTH PT	1, 304, 633	158, 008 11, 158	1, 462, 64° 11, 158		687, 246 522, 688	
67. 00	06700 OCCUPATI ONAL THERAPY		11, 130	11, 130	456, 893	456, 893	
67. 01	06701 KV HEALTH OT	0	0	(146, 178		
68. 00	06800 SPEECH PATHOLOGY	0	0	(143, 836	143, 836	
68. 01	06801 KV HEALTH ST	0	0	(108, 833		
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	9	0	105.254	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT		0		185, 356 42, 657	185, 356 42, 657	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0		0 42,037	0	1
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	187, 123	98, 293				
88. 03 89. 00	08801 RURAL HEALTH CLINIC IV 08900 FEDERALLY QUALIFIED HEALTH CENTER	189, 237	107, 464	296, 70	0	296, 701 0	1
	09000 CLINIC	699, 807	204, 568	904, 37!	5 -113, 515		
91. 00	09100 EMERGENCY	949, 326	1, 060, 685				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
93. 00	04040 FAMILY PRACTICE	0	0	(0 0	0	93. 00
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	1, 409, 850	194, 989	1, 604, 839	-128, 606	1, 476, 233	101 00
101.00	SPECIAL PURPOSE COST CENTERS	1, 407, 650	174, 707	1, 004, 03	- 128, 000	1, 470, 233	1101.00
116.00	11600 HOSPI CE	0	289, 325	289, 32	128, 606	417, 931	116. 00
118. 00	,	14, 714, 309	20, 353, 356	35, 067, 66	592, 209	35, 659, 874	118. 00
100.00	NONREI MBURSABLE COST CENTERS		0			0	100.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		190. 00 192. 00
192. 01	19201 RENSSELAER HEALTH CENTER	0	0		o o		192. 01
	19300 NONPALD WORKERS	0	0	(0	0	193. 00
	07950 ALTERNACARE	464, 603	18, 343			482, 946	
	07951 DME EQUI PMENT	002 120	2, 789	2, 789			194. 01
	07952 KV HEALTH CENTER 07957 ST. JOE HEALTH CENTER	803, 138 51, 794	118, 101 140	921, 23 ⁹ 51, 93		329, 364 51, 934	194. 02
	07953 FOUNDATION	0	0	1	14, 170		194. 04
194.05	07954 MEALS ON WHEELS	0	0	(0	0	194. 05
	07955 WATER LAB	54, 023	20, 938				194. 06
	07956 ADVERTI SI NG	45, 865	53, 856				194. 07
200.00	TOTAL (SUM OF LINES 118-199)	16, 133, 732	20, 567, 523	36, 701, 25!	0	36, 701, 255	J∠UU. UU

 Health Financial
 Systems
 JASPER CORRECTOR

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 151324 Peri od: Worksheet A From 01/01/2014 Date/Time Prepared:

				10 12/31/2014 Date/lime F 12/21/2015	
	Cost Center Description	Adjustments	Net Expenses	12,21,2010	2.07 p
		(See A-8)	For Allocation	<u>1</u>	
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-96, 033	2, 007, 452	2	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-96, 720			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-1, 458, 677		1	5. 00
7.00	00700 OPERATION OF PLANT	0	.,,	l .	7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	109, 404 462, 191	l .	8. 00 9. 00
10.00	01000 DI ETARY	-25, 249		l .	10.00
11. 00	01100 CAFETERI A	-29, 084		l .	11. 00
13.00	01300 NURSING ADMINISTRATION	0		l .	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	31, 146		14. 00
15. 00	01500 PHARMACY	-50, 518			15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-12, 901	371, 240		16. 00 17. 00
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	49, 810	J	17.00
30. 00	03000 ADULTS & PEDIATRICS	-12, 363	1, 674, 845	5	30.00
31.00	03100 INTENSIVE CARE UNIT	-2, 225	690, 592		31.00
41. 00	04100 SUBPROVI DER - I RF	0		1	41. 00
42.00	04200 SUBPROVI DER	0		1	42. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	132, 342	2	43. 00
50. 00	05000 OPERATI NG ROOM	-410, 025	2, 301, 605	5	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		•	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-3, 775	2, 743, 910		54.00
57. 00	05700 CT SCAN	0			57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	1, 743, 102		59. 00 60. 00
60. 01	06001 BLOOD LABORATORY				60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0			63. 00
65. 00	06500 RESPI RATORY THERAPY	0	1, 038, 534	1	65. 00
66. 00	06600 PHYSI CAL THERAPY	-1, 575	· ·	l .	66. 00
66. 01	06601 KV HEALTH PT	0		l .	66. 01 67. 00
67. 00 67. 01	06700 OCCUPATI ONAL THERAPY 06701 KV HEALTH OT	0	456, 893 146, 178	l .	67.00
68. 00	06800 SPEECH PATHOLOGY		143, 836	l .	68. 00
68. 01	06801 KV HEALTH ST	0	108, 833		68. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-1, 141	184, 215	l .	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0		l control of the cont	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	J	73. 00
88. 00	08800 RURAL HEALTH CLINIC	-6, 420	278, 996	5	88. 00
88. 03		0	296, 701		88. 03
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90.00	1	-57, 189			90.00
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	-3, 675	1, 964, 638	3	91. 00 92. 00
	04040 FAMILY PRACTICE	0	0		93. 00
	OTHER REIMBURSABLE COST CENTERS	_			
101.00	10100 HOME HEALTH AGENCY	0	1, 476, 233	3	101. 00
	SPECIAL PURPOSE COST CENTERS	1 -		.1	
	0 11600 HOSPI CE	0			116.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	-2, 267, 570	33, 392, 304	 	118. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	Ιο	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0			192. 00
	1 19201 RENSSELAER HEALTH CENTER	0	0		192. 01
	19300 NONPALD WORKERS	0	0		193. 00
	07950 ALTERNACARE	0	482, 946	l .	194. 00
	1 07951 DME_EQUIPMENT 2 07952 KV_HEALTH_CENTER		2, 789 329, 364		194. 01 194. 02
	3 07957 ST. JOE HEALTH CENTER		51, 934	l .	194. 02
	4 07953 FOUNDATION	0	14, 170	l .	194. 04
194. 0	07954 MEALS ON WHEELS	0	0		194. 05
	07955 WATER LAB	0	,	·	194. 06
	7 07956 ADVERTI SI NG	0	,	•	194. 07
200. 00	TOTAL (SUM OF LINES 118-199)	-2, 267, 570	34, 433, 685	PI	200. 00

Health Financial Systems RECLASSIFICATIONS JASPER COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 151324

Period: From 01/01/2014 To 12/31/2014 Worksheet A-6 Date/Time Prepared: 12/21/2015 2:09 pm

						12/21/2015 2:09 pr
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00	 	
	A - CAFETERIA					
1.00	CAFETERI A	1100	16 <u>1, 9</u> 97	1 <u>0, 9</u> 53		1.
	0		161, 997	10, 953		
	B - HOSPI CE					
1. 00	HOSPICE	1 <u>16.</u> 00	12 <u>8, 6</u> 06	0		1.
	0		128, 606	0		
	C - OB	40.00	404.040	0.070		
1.00	NURSERY	43.00	124, 263	8, 079		1.
2. 00	DELI VERY ROOM & LABOR ROOM	<u>52.</u> 00	12, 426	808		2.
	0		136, 689	8, 887		
	D - CHARGEABLE SUPPLIES	74 00		202 242		
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	228, 013		1.
0 00	PATI ENTS	0.00				
2.00		0.00	0	0		2.
3.00		0.00	0	0		3.
4.00		0.00	0	0		4.
5.00		0.00	0	0		5.
6.00		0.00	0	0		6.
7. 00		0.00		228, 013		7.
	E - KV CENTER RECLASS		U	228, 013		
1. 00	KV HEALTH PT	66. 01	445, 953	65, 577		1.
2. 00	KV HEALTH OT	67. 01	127, 438	18, 740		2.
2. 00 3. 00	KV HEALTH ST	68. 01	94, 881	13, 952		3.
3.00	N IIIALIII 31		668, 272	98, 269		3.
	F - ADVERTISING		000, 272	70, 207		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	6, 671	7, 833		1.
1.00	0	— — " "	$\frac{1}{6,671}$	$-\frac{7,833}{7,833}$		
	G - PROPERTY INSURANCE		0, 0, 1	7,000		
1. 00	NEW CAP REL COSTS-BLDG &	1.00	0	70, 231		1.
	FIXT		٩	70720.		
	0	+		70, 231		
	H - REHAB RECLASS		-1			
1. 00	OCCUPATI ONAL THERAPY	67.00	437, 711	19, 182		1.
2. 00	SPEECH PATHOLOGY	68.00	137, 797	6, 039		2.
3. 00	KV HEALTH CENTER	194. 02	167, 333	7, 333		3.
			742, 841	32, 554		
	I - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO	72.00	0	42, 657	 	1.
	PATI ENT					
	0		0	42, 657		
	J - SOCIAL SERVICE RECLASS					
1.00	SOCI AL SERVI CE	1700	49, 773	0		1.
	0		49, 773	0		
	K - FOUNDATION RECLASS					
. 00	FOUNDATI ON	194. 04	0	<u>14, 1</u> 70	 	1.
	TOTALS		0	14, 170		
500.00	Grand Total: Increases		1, 894, 849	513, 567		500.

| Peri od: | Worksheet A-6 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

					'	12/21/2015 2:09 pm
		Decreases		•		
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
	A - CAFETERIA				1	
1.00	DI ETARY	10.00	161, 997	10, 953		1. 00
	0		161, 997	10, 953		
	B - HOSPI CE					
1.00	HOME HEALTH AGENCY	1 <u>01.</u> 00	128, 606	0	0	1. 00
	0		128, 606			
4 00	C - OB	20.00	407 (00	0.007		
1.00	ADULTS & PEDIATRICS	30.00	136, 689	8, 887		1. 00
2.00		0.00			0	2. 00
	D - CHARGEABLE SUPPLIES		136, 689	8, 887		
1. 00	ADULTS & PEDIATRICS	30.00	ما	19, 884		1. 0
2. 00	INTENSIVE CARE UNIT	31. 00	0	5, 866		2.0
3.00	OPERATING ROOM	50.00	0	249		3. 0
4. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	45, 411	1	4. 0
5.00	RESPIRATORY THERAPY	65.00	0	1, 390		5. 0
6. 00	CLI NI C	90.00	0	113, 515		6. 0
7. 00	EMERGENCY	91.00	0	41, 698		7. 0
7.00	0		 	228, 013		7.0
	E - KV CENTER RECLASS		<u> </u>	220,013	'	
1. 00	KV HEALTH CENTER	194. 02	668, 272	98, 269	o	1. 0
2. 00	N. HEALTH GENTER	0.00	0	70, 207	_	2. 00
3.00		0.00	0	0	0	3. 00
0.00			668, 272	98, 269	<u> </u>	
	F - ADVERTISING		333, 2.2	,		
1.00	ADVERTI SI NG	194. 07	6, 671	7, 833	0	1. 0
			6, 671	7, 833		
	G - PROPERTY INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	70, 231	12	1. 0
				70, 231		
	H - REHAB RECLASS					
1.00	PHYSI CAL THERAPY	66. 00	742, 841	32, 554	. 0	1. 0
2.00		0.00	0	C	0	2. 0
3.00		000	0	0	0	3. 0
	0		742, 841	32, 554		
	I - IMPLANTABLE DEVICES					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	42, 657	0	1.00
	PATI ENTS	+				
	0		0	42, 657		
	J - SOCIAL SERVICE RECLASS				1	
1.00	ADMI NI STRATI VE & GENERAL		49, 773	0	0	1. 00
	0		49, 773	C		
	K - FOUNDATION RECLASS		_1		.1 -1	
1. 00	ADMI NI STRATI VE & GENERAL			14, 170		1. 00
E00 00	TOTALS		0	14, 170		500.0
500.00	Grand Total: Decreases		1, 894, 849	513, 567	1	500. 0

Provider CCN: 151324 | Period: | Worksheet A-7 | Provider | Provid Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

				T	o 12/31/2014	Date/Time Prep	
						12/21/2015 2:0)9 pm
			D 1	Acqui si ti ons	T	l	
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances	2. 00	3.00	4. 00	Retirements 5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	1.00 T BALANCES	2.00	3.00	4.00	5.00	
1. 00	Land	53, 965	0		_	0	1. 00
2.00		1, 859, 740	0	0	0		2. 00
3.00	Land Improvements		0	0	0		
	Buildings and Fixtures	22, 406, 327	0	0	0	0	3. 00
4.00	Building Improvements	0 204 707	0 (07 107	0	0 (07 107	(0.15)	4. 00
5.00	Fi xed Equipment	8, 306, 797	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, 150	7. 00
8. 00	Subtotal (sum of lines 1-7)	32, 626, 829	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)	32, 626, 829	2, 687, 187	0	2, 687, 187	69, 152	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
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	Fi xed Equipment	10, 924, 832	0				5.00
6.00	Movable Equipment	0	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	35, 244, 864	0				8.00
9.00	Reconciling Items	o	0				9.00
10. 00	Total (line 8 minus line 9)	35, 244, 864	0			ļ	10. 00

Heal th	n Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
					From 01/01/2014 To 12/31/2014		pared·
						12/21/2015 2:	
			SU	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	,	
						instructions)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORL	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 343, 999	7, 020	667, 86	0	0	1.00
3.00	Total (sum of lines 1-2)	1, 343, 999	7, 020	667, 86	0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	14, 375	2, 033, 254				1. 00
3.00	Total (sum of lines 1-2)	14, 375	2, 033, 254				3. 00

Heal th	Financial Systems	JASPER COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
					From 01/01/2014 To 12/31/2014		pared.
						12/21/2015 2:0	
		COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized	Gross Assets	Ratio (see	Insurance	
	·		Leases	for Ratio	instructions)		
				(col. 1 - col			
				2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		_	1		_	
1.00	NEW CAP REL COSTS-BLDG & FIXT	35, 244, 864	l e	35, 244, 86			1.00
3.00	Total (sum of lines 1-2)	35, 244, 864		35, 244, 86	_		3. 00
		ALLUCA	TION OF OTHER (LAPITAL	SUMMARY C	OF CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)	0.00	10.00	
	DADT III DECONCILIATION OF CADITAL COCTE OF	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CENEW CAP REL COSTS-BLDG & FIXT	INTERS		1	0 1 247 0//	7 000	1. 00
3. 00	Total (sum of lines 1-2)	0	0		0 1, 247, 966 0 1, 247, 966		3. 00
3.00	Total (Suil of Titles 1-2)	U	<u> </u>	L JMMARY OF CAPI		7,020	3.00
			30	DIVINIART OF CAFT	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)		
	DADT 111 DECONOLITION OF CARLETT CO.	11.00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	NEW CAP REL COSTS-BLDG & FIXT	667, 860			0 14, 375		1.00
3.00	Total (sum of lines 1-2)	667, 860	70, 231		0 14, 375	2, 007, 452	3.00

In Lieu of Form CMS-2552-10 Health Financial Systems JASPER COUNTY HOSPITAL ADJUSTMENTS TO EXPENSES Provider CCN: 151324 Peri od: Worksheet A-8 From 01/01/2014 12/31/2014 Date/Time Prepared: 12/21/2015 2:09 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1. 00 1.00 REL COSTS-BLDG & FIXT (chapter IFI XT 2.00 Investment income - CAP REL 0 *** Cost Center Deleted *** 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 3.00 0.00 (chapter 2) Trade, quantity, and time 4.00 4.00 0 00 di scounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by suppliers (chapter 8) 6.00 0.00 6.00 7 00 7.00 Tel ephone servi ces (pay 0.00 stations excluded) (chapter 8.00 Television and radio service 0.00 8.00 (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 10.00 Provi der-based physician A-8-2 10.00 adj ustment Sale of scrap, waste, etc. 11.00 0.00 11.00 (chapter 23) Related organization A-8-1 12.00 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 Cafeteria-employees and guests 0.00 14.00 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others 16 00 Sale of medical and surgical 0 00 16 00 supplies to other than pati ents Sale of drugs to other than 0.00 17.00 17.00 0 pati ents 18.00 Sale of medical records and -10, 532 MEDI CAL RECORDS & LI BRARY 18.00 В 16.00 abstracts 19.00 Nursing school (tuition, fees, 0 19.00 0.00 books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24 00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 26.00 1.00 26.00 COSTS-BLDG & FLXT FI XT Depreciation - CAP REL 0 *** Cost Center Deleted *** 27.00 2.00 27.00 COSTS-MVBLE EQUIP 28.00 0 *** Cost Center Deleted *** 19.00 28.00 Non-physician Anesthetist Physicians' assistant 29 00 29.00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14)

-81,658 NEW CAP REL COSTS-BLDG &

IFI XT

-1, 575 PHYSI CAL THERAPY

32.00

0 33.00

1.00

66.00

CAH HIT Adjustment for

33.00 WELLNESS PROGRAM FEE

Depreciation and Interest

Α

В

32.00

Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted To/From Which the Amount					To	12/31/2014	Date/Time Pre	
To/From Which the Amount is to be Adjusted To/From Which the Amount is to a solution To/From Which the Amount is to To/From Which the Amount is to					Expense Classification on	Worksheet A	12/21/2013 2.	07 piii
Cost Center Description								
1.00 2.00 3.00 4.00 5.00 3.4					To the file file file of the f	to be hajusted		
1.00 2.00 3.00 4.00 5.00 3.4								
1.00 2.00 3.00 4.00 5.00 3.4								
1.00 2.00 3.00 4.00 5.00 3.4								
34.00 MEALS ON WHEELS B -25,249 DIETARY 10.00 0 34.00 35.00 MISCELLANEOUS INCOME BENEFITS B -96,720 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 35.00 36.00 MISCELLANEOUS INCOME ADMIN B -322,681 ADMIN ISTRATIVE & GENERAL 5.00 0 36.00 39.00 MISCELLANEOUS INCOME MEDICAL B -50,518 PHARMACY 15.00 0 38.00 0 39.00 MISCELLANEOUS INCOME MEDICAL B -23,69 MEDICAL RECORDS & LI BRARY 16.00 0 39.00 0 0 0 0 0 0 0 0 0		Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
35.00 MI SCELLANEOUS INCOME BENEFITS B -96,720 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 35.00 36.00 MI SCELLANEOUS INCOME ADMIN B -322,681 ADMIN IN STRATIV & GENERAL 5.00 0 36.00 36.00 MI SCELLANEOUS INCOME MEDICAL B -50,518 PHARMACY 15.00 0 39.00 MI SCELLANEOUS INCOME MEDICAL B -2,369 MEDICAL RECORDS & LI BRARY 16.00 0 39.00 41.00 MI SCELLANEOUS INCOME A&P B -63 ADULTS & PEDIATRICS 30.00 0 41.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 41.00 42.00 43.00 MI SCELLANEOUS INCOME CARE B -52,614 CLI NIC 90.00 0 43.00 45		·	1.00	2.00	3.00	4. 00	5. 00	
36. 00 MI SCELLANEOUS I NCOME ADMIN B -322, 681 ADMIN STRATI VE & GENERAL 5. 00 0 36. 00 38. 00 MI SCELLANEOUS I NCOME PHARMACY B -50. 518 PHARMACY 15. 00 0 39. 00 0 39. 00 0 0 0 0 0 0 0 0 0	34.00	MEALS ON WHEELS	В	-25, 249	DI ETARY	10.00	0	34.00
38.00 MI SCELLANEOUS I NCOME PHARMACY B -50,518 PHARMACY 15.00 0 38.00 39.00 NI SCELLANEOUS I NCOME MEDI CAL RECORDS B LI BRARY 16.00 0 39.00 NI SCELLANEOUS I NCOME ABP B -63 ADULTS & PEDI ATRICS 30.00 0 40.00 41.00 NI SCELLANEOUS SUPPLIES B -1,411 NEDI CAL SUPPLIES CHARGED TO PATI ENTS 71.00 0 41.00 NI SCELLANEOUS SUPPLIES B -1,411 NEDI CAL SUPPLIES CHARGED TO PATI ENTS 71.00 0 41.00 NI SCELLANEOUS I NCOME CLI NI C B -6,420 RURAL HEALTH CLI NI C 88.00 0 42.00 43.00 NI SCELLANEOUS I NCOME CARE B -6,5,614 CLI NI C 90.00 0 43.00 0 44.00 LI FELI NE B -2,000 EMERGENCY 91.00 0 44.00 145.01 CAFETERI A A -2,000 EMERGENCY 91.00 0 45.01 11.00 0 14.01 11.00 0 14.01 11.00 0 14.01 11.00 0 14.01 11.00 0 14.01 11.00 0 14	35.00	MISCELLANEOUS INCOME BENEFITS	В	-96, 720	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35. 00
39.00 MI SCELLANEOUS I NCOME MEDI CAL B -2,369 MEDI CAL RECORDS & LI BRARY 16.00 0 39.00 0 40.00 41.00 MI SCELLANEOUS SUPPLIES B -63 ADULTS & PEDI ATRI CS 30.00 0 40.00 41.00 41.00 MI SCELLANEOUS SUPPLIES B -1,141 MEDI CAL SUPPLIES CHARGED TO 71.00 0 41.00 41.00 42.00 43.00 MI SCELLANEOUS I NCOME CLI NI C B -6,420 CAPRURAL HEALTH CLI NI C 90.00 0 43.00 44.00 LI FELI NE B -2,000 EMERGENCY 91.00 0 44.00 45.00	36.00	MISCELLANEOUS INCOME ADMIN	В	-322, 681	ADMINISTRATIVE & GENERAL	5. 00	0	36.00
RECORDS	38.00	MI SCELLANEOUS I NCOME PHARMACY	В	-50, 518	PHARMACY	15. 00	0	38. 00
40. 00 MI SCELLANEOUS I NCOME A&P B -63 ADULTS & PEDI ATRI CS 30. 00 0 40. 00 41. 00 MI SCELLANEOUS SUPPLIES B -1. 141 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 71. 00 0 41. 00 41.	39.00	MISCELLANEOUS INCOME MEDICAL	В	-2, 369	MEDICAL RECORDS & LIBRARY	16.00	0	39. 00
A1. 00		RECORDS						
PATI ENTS PATI	40.00	MISCELLANEOUS INCOME A&P	В	-63	ADULTS & PEDIATRICS	30.00	0	40.00
42. 00 MI SCELLANEOUS I NCOME CLINI C B -6, 420 RURAL HEALTH CLINI C 90. 00 0 42. 00 43. 00 MI SCELLANEOUS I NCOME CARE B -52, 614 (CLINI C 90. 00 0 43. 00 44. 00 LI FELI NE B -2, 000 [MERGENCY 91. 00 0 44. 00 45. 00 MI SCELLANEOUS I NCOME ADMIN B -167 ADMIN IN STRATI VE & GENERAL 5. 00 0 45. 01 45. 01 CAFETERI A 11. 00 0 45. 01 45. 02 INTEREST I NCOME A -2, 2523 ADMIN ISTRATI VE & GENERAL 5. 00 0 45. 02 45. 03 LOBBYING EXPENSE A -634 ADMIN ISTRATI VE & GENERAL 5. 00 0 45. 03 45. 04 GOODWI LL AMORTI ZATI ON A -14, 375 NEW CAP REL COSTS-BLDG & 1. 00 9 45. 04 45. 05 ANESTHESI A OFFSET A -12, 300 ADULTS & PEDI ATRI CS 30. 00 0 45. 05 45. 06 ANESTHESI A OFFSET A -410, 025 OPERATI NG ROOM 50. 00 0 45. 07 45. 08 ANESTHESI A OFFSET A -3, 775 RADI OLOGY-DI AGNOSTI C 54. 00 0 45. 08 45. 09 ANESTHESI A OFFSET A -4, 575 CLINI C 90. 00 0 45. 08 45. 10 ANESTHESI A OFFSET A -1, 675 EMERGENCY 91. 00 0 45. 10 45. 11 HAF OFFSET A -1, 132, 672 ADMIN ISTRATI VE & GENERAL 5. 00 0 45. 10 45. 12 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	41.00	MI SCELLANEOUS SUPPLI ES	В	-1, 141	MEDICAL SUPPLIES CHARGED TO	71.00	0	41.00
43. 00 MI SCELLANEOUS I NCOME CARE B -52, 614 CLINIC 90. 00 0 43. 00 44. 00 LI FELI NE B -2, 000 EMERGENCY 91. 00 0 44. 00 45. 00 MI SCELLANEOUS I NCOME ADMIN B -167 ADMIN ISTRATI VE & GENERAL 5. 00 0 45. 00 45. 01 CAFETERI A 11. 00 0 45. 01 45. 01 INTEREST I NCOME A -29, 084 CAFETERI A 11. 00 0 45. 01 45. 02 LOBBYI NG EXPENSE A -634 ADMIN ISTRATI VE & GENERAL 5. 00 0 45. 03 45. 04 GOODWI LL AMORTI ZATI ON A -14, 375 NEW CAP REL COSTS-BLDG & 1. 00 9 45. 04 45. 05 ANESTHESI A OFFSET A -12, 300 ADULTS & PEDI ATRI CS 30. 00 0 45. 05 45. 06 ANESTHESI A OFFSET A -2, 225 INTENSI VE CARE UNIT 31. 00 0 45. 06 45. 07 ANESTHESI A OFFSET A -410, 025 OPERATI NG ROOM 50. 00 0 45. 07 45. 08 ANESTHESI A OFFSET A -3, 775 RADI OLOGY-DI AGNOSTI C 54. 00 0 45. 08 45. 09 ANESTHESI A OFFSET A -1, 675 EMERGENCY 91. 00 0 45. 10 45. 11 HAF OFFSET A -1, 132, 672 ADMIN ISTRATI VE & GENERAL 5. 00 0 45. 11 45. 12 0 0 0 0 45. 12 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)					PATI ENTS			
A4. 00	42.00	MISCELLANEOUS INCOME CLINIC	В	-6, 420	RURAL HEALTH CLINIC	88. 00	0	42.00
45. 00 MI SCELLANEOUS INCOME ADMIN B -167 ADMINI STRATI VE & GENERAL 5. 00 0 45. 00 45. 01 45. 01 (AFETERIA A -29, 084 CAFETERIA A -29, 084 CAFETERIA 11. 00 0 45. 01 45. 02 (AFETERIA A -29, 084 CAFETERIA A -29, 084 CAFETERIA 11. 00 0 45. 01 45. 02 (AFETERIA A -29, 084 CAFETERIA A -29, 084 CAFETERIA 11. 00 0 45. 01 45. 02 (AFETERIA A -29, 084 CAFETERIA A -375 NEW CAP REL COSTS-BLDG & 1. 00 0 45. 03 (AFETERIA A -14, 375 NEW CAP REL COSTS-BLDG & 1. 00 9 45. 04 (AFETERIA A OFFSET A A -12, 300 ADULTS & PEDIATRICS 30. 00 0 45. 05 (AFETERIA A OFFSET A A -2, 225 INTENSI VE CARE UNIT 31. 00 0 45. 06 (AFETERIA A OFFSET A A -410, 025 OPERATING ROOM 50. 00 0 45. 07 (AFETERIA A OFFSET A A -3, 775 RADIO LOGY-DI AGNOSTI C 54. 00 0 45. 08 (AFETHESIA OFFSET A A -4, 575 CLI NI C 90. 00 0 45. 09 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 11 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 11 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 11 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 11 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 11 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 12 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 12 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 12 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 12 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 12 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 12 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 12 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 12 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 12 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 12 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 12 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 12 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 12 (AFETERIA A OFFSET A A -1, 675 EMERGENCY 91. 00 0 45. 12 (AFETERIA A OFFSET A A OFFSET A A -1, 675 EMERGEN	43.00	MISCELLANEOUS INCOME CARE	В	-52, 614	CLINIC	90.00	0	43.00
45. 01 CAFETERIA A -29, 084 CAFETERIA 11. 00 0 45. 01 45. 02 INTEREST INCOME A -2, 523 ADMINISTRATIVE & GENERAL 5. 00 0 45. 02 45. 03 LOBBYING EXPENSE A -634 ADMINISTRATIVE & GENERAL 5. 00 0 45. 03 45. 04 GOODWILL AMORTIZATION A -14, 375 NEW CAP REL COSTS-BLDG & 1. 00 9 45. 04 45. 05 ANESTHESIA OFFSET A -12, 300 ADULTS & PEDIATRICS 30. 00 0 45. 05 45. 06 ANESTHESIA OFFSET A -2, 225 INTENSIVE CARE UNIT 31. 00 0 45. 06 45. 07 ANESTHESIA OFFSET A -410, 025 OPERATING ROOM 50. 00 0 45. 06 45. 08 ANESTHESIA OFFSET A -3, 775 RADIOLOGY-DIAGNOSTIC 54. 00 0 45. 08 45. 09 ANESTHESIA OFFSET A -4, 575 CLINIC 90. 00 0 45. 09 45. 10 ANESTHESIA OFFSET A -1, 675 EMERGENCY 91. 00 0 45. 11 45. 12 0 0 0 0 45. 12 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	44.00	LI FELI NE	В	-2, 000	EMERGENCY	91.00	0	44.00
45. 02 INTEREST INCOME 45. 03 LOBBYING EXPENSE A -634 ADMINISTRATIVE & GENERAL 5. 00 0 45. 02 45. 04 GOODWILL AMORTIZATION A -14, 375 NEW CAP REL COSTS-BLDG & 1. 00 9 45. 04 45. 05 ANESTHESIA OFFSET A -12, 300 ADULTS & PEDIATRICS 30. 00 0 45. 05 45. 06 ANESTHESIA OFFSET A -2, 225 INTENSIVE CARE UNIT 31. 00 0 45. 06 45. 07 ANESTHESIA OFFSET A -410, 025 OPERATING ROOM 50. 00 0 45. 07 45. 08 ANESTHESIA OFFSET A -3, 775 RADIOLOGY-DIAGNOSTIC 50. 00 0 45. 09 45. 10 ANESTHESIA OFFSET A -1, 675 EMERGENCY 91. 00 0 45. 10 45. 11 HAF OFFSET A -1, 132, 672 ADMINISTRATIVE & GENERAL 5. 00 0 45. 02 50. 00 0 45. 02 50. 00 0 45. 11 50. 00 0 45. 12 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	45.00	MISCELLANEOUS INCOME ADMIN	В	-167	ADMINISTRATIVE & GENERAL	5. 00	0	45. 00
45. 03 LOBBYING EXPENSE A -634 ADMINISTRATIVE & GENERAL 5. 00 0 45. 03 45. 04 GOODWILL AMORTIZATION A -14, 375 NEW CAP REL COSTS-BLDG & 1. 00 9 45. 04 FIXT 31. 00 0 45. 05 ANESTHESIA OFFSET A -22, 225 INTENSIVE CARE UNIT 31. 00 0 45. 06 ANESTHESIA OFFSET A -21, 300 ADULTS & PEDIATRICS 30. 00 0 45. 06 45. 07 ANESTHESIA OFFSET A -410, 025 OPERATING ROOM 50. 00 0 45. 07 45. 08 ANESTHESIA OFFSET A -3, 775 RADIOLOGY-DIAGNOSTIC 54. 00 0 45. 08 45. 09 ANESTHESIA OFFSET A -4, 575 CLINIC 90. 00 0 45. 09 45. 10 ANESTHESIA OFFSET A -1, 675 EMERGENCY 91. 00 0 45. 11 45. 12 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	45. 01	CAFETERI A	A	-29, 084	CAFETERI A	11. 00	0	45. 01
45. 04 GOODWILL AMORTIZATION A -14, 375 NEW CAP REL COSTS-BLDG & 1. 00 9 45. 04 FIXT 45. 05 ANESTHESIA OFFSET A -12, 300 ADULTS & PEDIATRICS 30. 00 0 45. 05 45. 06 ANESTHESIA OFFSET A -2, 225 INTENSIVE CARE UNIT 31. 00 0 45. 06 45. 07 ANESTHESIA OFFSET A -410, 025 OPERATING ROOM 50. 00 0 45. 07 45. 08 ANESTHESIA OFFSET A -3, 775 RADIOLOGY-DIAGNOSTIC 54. 00 0 45. 08 45. 09 ANESTHESIA OFFSET A -4, 575 CLINIC 90. 00 0 45. 09 45. 10 ANESTHESIA OFFSET A -1, 675 EMERGENCY 91. 00 0 45. 11 45. 12 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	45.02	INTEREST INCOME	A	-2, 523	ADMINISTRATIVE & GENERAL	5. 00	0	45. 02
45. 05 ANESTHESIA OFFSET A -12, 300 ADULTS & PEDIATRICS 30. 00 0 45. 05 45. 06 ANESTHESIA OFFSET A -2, 225 INTENSIVE CARE UNIT 31. 00 0 45. 06 45. 07 ANESTHESIA OFFSET A -410, 025 OPERATING ROOM 50. 00 0 45. 07 45. 08 ANESTHESIA OFFSET A -3, 775 RADIOLOGY-DIAGNOSTIC 54. 00 0 45. 08 45. 09 ANESTHESIA OFFSET A -4, 575 CLINIC 90. 00 0 45. 09 45. 10 ANESTHESIA OFFSET A -1, 675 EMERGENCY 91. 00 0 45. 10 45. 11 HAF OFFSET A -1, 132, 672 ADMINISTRATIVE & GENERAL 5. 00 0 45. 11 45. 12 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	45.03	LOBBYING EXPENSE	A	-634	ADMINISTRATIVE & GENERAL	5. 00	0	45. 03
45. 05 ANESTHESIA OFFSET A -12, 300 ADULTS & PEDIATRICS 30. 00 0 45. 05 45. 06 ANESTHESIA OFFSET A -2, 225 INTENSIVE CARE UNIT 31. 00 0 45. 06 45. 07 ANESTHESIA OFFSET A -410, 025 OPERATING ROOM 50. 00 0 45. 07 45. 08 ANESTHESIA OFFSET A -3, 775 RADIOLOGY-DIAGNOSTIC 54. 00 0 45. 08 45. 09 ANESTHESIA OFFSET A -4, 575 CLINIC 90. 00 0 45. 09 45. 10 ANESTHESIA OFFSET A -1, 675 EMERGENCY 91. 00 0 45. 10 45. 11 HAF OFFSET A -1, 132, 672 ADMINISTRATIVE & GENERAL 5. 00 0 45. 11 45. 12 0 0 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	45.04	GOODWILL AMORTIZATION	A	-14, 375	NEW CAP REL COSTS-BLDG &	1.00	9	45. 04
45. 06 ANESTHESIA OFFSET A -2, 225 INTENSIVE CARE UNIT 31. 00 0 45. 06 45. 07 ANESTHESIA OFFSET A -410, 025 OPERATING ROOM 50. 00 0 45. 07 45. 08 ANESTHESIA OFFSET A -3, 775 RADI OLOGY-DI AGNOSTI C 54. 00 0 45. 08 45. 09 ANESTHESIA OFFSET A -4, 575 CLINIC 90. 00 0 45. 09 45. 10 ANESTHESIA OFFSET A -1, 675 EMERGENCY 91. 00 0 45. 10 45. 11 HAF OFFSET A -1, 132, 672 ADMINISTRATIVE & GENERAL 5. 00 0 45. 11 45. 12 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)					FLXT			
45. 07 ANESTHESIA OFFSET A -410, 025 OPERATING ROOM 50. 00 45. 07 45. 08 ANESTHESIA OFFSET A -3, 775 RADI OLOGY-DI AGNOSTI C 54. 00 0 45. 08 45. 09 ANESTHESIA OFFSET A -4, 575 CLINI C 90. 00 0 45. 09 45. 10 ANESTHESIA OFFSET A -1, 675 EMERGENCY 91. 00 0 45. 10 45. 11 HAF OFFSET A -1, 132, 672 ADMINISTRATI VE & GENERAL 5. 00 0 45. 11 45. 12 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	45.05		A				0	
45. 08 ANESTHESIA OFFSET A -3, 775 RADI OLOGY-DI AGNOSTI C 54. 00 0 45. 08 45. 09 ANESTHESIA OFFSET A -4, 575 CLINI C 90. 00 0 45. 09 45. 10 ANESTHESIA OFFSET A -1, 675 EMERGENCY 91. 00 0 45. 10 45. 11 HAF OFFSET A -1, 132, 672 ADMINISTRATI VE & GENERAL 5. 00 0 45. 11 45. 12 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	45.06	ANESTHESI A OFFSET	A	-2, 225	INTENSIVE CARE UNIT	31.00	0	45. 06
45. 09 ANESTHESIA OFFSET A -4, 575 CLINIC 90. 00 0 45. 09 45. 10 ANESTHESIA OFFSET A -1, 675 EMERGENCY 91. 00 0 45. 10 45. 11 HAF OFFSET A -1, 132, 672 ADMINISTRATIVE & GENERAL 5. 00 0 45. 11 45. 12 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	45. 07	ANESTHESI A OFFSET	A	-410, 025	OPERATING ROOM	50.00	0	45. 07
45. 10 ANESTHESIA OFFSET A -1, 675 EMERGENCY 91. 00 0 45. 10 45. 11 HAF OFFSET A -1, 132, 672 ADMINISTRATIVE & GENERAL 5. 00 0 45. 11 45. 12 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	45.08	ANESTHESI A OFFSET	A	-3, 775	RADI OLOGY-DI AGNOSTI C	54.00	0	45. 08
45. 11 HAF OFFSET A -1, 132, 672 ADMINISTRATIVE & GENERAL 5. 00 0 45. 11 45. 12 0 0.00 0 45. 12 50. 00 TOTAL (sum of lines 1 thru 49)	45. 09	ANESTHESI A OFFSET	A	-4, 575	CLINIC	90.00	0	45. 09
45. 12	45. 10	ANESTHESI A OFFSET	A	-1, 675	EMERGENCY	91.00	0	45. 10
50.00 TOTAL (sum of lines 1 thru 49)	45. 11	HAF OFFSET	A	-1, 132, 672	ADMINISTRATIVE & GENERAL	5. 00	0	45. 11
(Transfer to Worksheet A, column 6, line 200.)	45. 12			0		0.00	0	45. 12
	50.00			-2, 267, 570				50.00

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

| Provider CCN: 151324 | Period: | Worksheet A-8-2 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

					-	Γο 12/31/2014	Date/Time Pre 12/21/2015 2:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	0 7 p
		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	60.00	LABORATORY	12, 000	0	1, 200	0	0	1. 00
2.00	91.00	EMERGENCY	759, 232	0	759, 232	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0. 00		0	0	0	0	0	5. 00
6.00	0. 00		0	0	0	0	O	6. 00
7.00	0. 00		0	0	0	0	o	7. 00
8.00	0.00		0	0	0	0	o	8. 00
9.00	0.00		0	0	0	0	o	9. 00
10.00	0.00		0	0	0	0	o	10.00
200.00			771, 232	0	760, 432		o	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	
1. 00		LABORATORY	0	0	-		0	1. 00
2.00		EMERGENCY	0	1			"	2.00
3.00	0. 00		0	0			0	3. 00
4.00	0. 00		0	0		-	0	4.00
5.00	0. 00		0	0	0	-	0	5. 00
6.00	0. 00		0	0	0	0	0	6. 00
7.00	0. 00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9. 00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l 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		LABORATORY	0	0				1. 00
2. 00		EMERGENCY	١	Ö		-		2. 00
3. 00	0.00		0	Ö				3. 00
4. 00	0.00		١	0		1		4. 00
5. 00	0.00		١	0	-			5. 00
6. 00	0.00		١	١	0			6. 00
7. 00	0.00		١	Ö	-			7. 00
8. 00	0.00		1 0	0				8. 00
9. 00	0.00		١	Ö	_	-		9. 00
10. 00	0.00		١	١	Ö			10. 00
200.00	3.00		٥	Ö				200. 00
_00.00	1		1	1	1	1	1 1	200.00

	Financial Systems	JASPER COUNTY H		ON 454004		u of Form CMS-2	
	NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provi der Co	CN: 151324	Peri od: From 01/01/2014 To 12/31/2014		pared:
					Physical Therapy		07 piii
						1. 00	
	PART I - GENERAL INFORMATION						
1. 00 2. 00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instruction	ons)			52 780	1. 00 2. 00
3. 00	Number of unduplicated days in which supervis	sor or therapist v	was on provide	er site (see	e instructions)	0	3.00
4. 00	Number of unduplicated days in which therapy	assistant was on				0	4. 00
5. 00	nor therapist was on provider site (see instructions) Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5. 00
6. 00	Number of unduplicated offsite visits - thera	apy assistants (i	nclude only vi	sits made b		0	6. 00
	assistant and on which supervisor and/or ther instructions)	rapist was not pr	esent during t	the visit(s)) (see		
7. 00	Standard travel expense rate					5. 51	7.00
8. 00	Optional travel expense rate per mile				1 4: 1	0.00	8. 00
		Supervi sors 7.00	Therapists 2.00	Assi stants 3.00	Ai des 4.00	Trai nees 5.00	
9. 00	Total hours worked	0. 00	1, 667. 00	0. (0.00	0.00	9. 00
	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0. 00 38. 70	77. 39	0.0		0. 00	
11. 00	one-half of column 2, line 10; column 3,	38. 70	38. 70	0.0	50		11.00
	one-half of column 3, line 10)		_				
	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		0		12. 00 12. 01
	Number of miles driven (provider site)	Ö	ő		Ö		13. 00
13. 01	Number of miles driven (offsite)	0	0		0		13. 01
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION	11 10					
	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					0 129, 009	14. 00 15. 00
	Assistants (column 3, line 9 times column 3,	line10)				0	16. 00
17. 00	Subtotal allowance amount (sum of lines 14 ar	nd 15 for respira	tory therapy o	or lines 14-	-16 for all	129, 009	17. 00
18. 00	others) Aides (column 4, line 9 times column 4, line	10)				0	18. 00
19. 00	Trainees (column 5, line 9 times column 5, li	ne 10)				0	19.00
20. 00	Total allowance amount (sum of lines 17-19 fo	or respiratory the				129, 009	20.00
		therapy or colum	nns 1_3 for nh	nvsical then		nology or	20.00
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						20.00
21 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete	line 2, make no lines 21-23.	entries on li	nes 21 and	22 and enter on	line 23	
21. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra	n line 2, make no lines 21-23. ainees (line 17 d	entries on li	nes 21 and	22 and enter on	line 23	
22. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained	n line 2, make no lines 21-23. ainees (line 17 d line 9 for all o	entries on li vided by sum thers)	nes 21 and	22 and enter on	0.00 0	21. 00 22. 00
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained Total salary equivalency (see instructions)	n line 2, make no lines 21-23. ainees (line 17 d line 9 for all o ees (line 2 times	entries on li vided by sum thers) line 21)	of columns	22 and enter on 1 and 2, line 9	0.00	21. 00 22. 00
22. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained	n line 2, make no lines 21-23. ainees (line 17 d line 9 for all o ees (line 2 times	entries on li vided by sum thers) line 21)	of columns	22 and enter on 1 and 2, line 9	0.00 0	21. 00 22. 00
22. 00 23. 00 24. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11)	n line 2, make no lines 21-23. ainees (line 17 d line 9 for all o ees (line 2 times	entries on li vided by sum thers) line 21)	of columns	22 and enter on 1 and 2, line 9	0.00 0 129,009	21. 00 22. 00 23. 00 24. 00
22. 00 23. 00 24. 00 25. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)	n line 2, make no lines 21-23. ainees (line 17 d line 9 for all o ees (line 2 times	vided by sum thers) line 21)	of columns	22 and enter on 1 and 2, line 9	0.00 0 129,009 0 0	21. 00 22. 00 23. 00 24. 00 25. 00
22. 00 23. 00 24. 00 25. 00 26. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11)	n line 2, make no lines 21-23. ainees (line 17 d line 9 for all o ees (line 2 times VANCE AND TRAVEL I	vided by sum thers) line 21) EXPENSE COMPUT	of columns TATION - PRO others)	22 and enter on 1 and 2, line 9 OVIDER SITE	0.00 0 129,009	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard	n line 2, make no lines 21-23. ainees (line 17 d line 9 for all o ees (line 2 times VANCE AND TRAVEL I	vided by sum thers) line 21) EXPENSE COMPUT	of columns TATION - PRO others) n of lines 3	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all	0.00 0 129,009 0 0 0	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel	n line 2, make no lines 21-23. ainees (line 17 d line 9 for all o ees (line 2 times MANCE AND TRAVEL I sum of lines 24 a for respiratory travel expense a Expense	vided by sum thers) line 21) EXPENSE COMPUT and 25 for all therapy or sum	of columns TATION - PRO others) n of lines 3	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all	0.00 0 129,009 0 0 0	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trainstal salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of	n line 2, make no lines 21-23. ainees (line 17 d line 9 for all o pees (line 2 times WANCE AND TRAVEL I for respiratory travel expense a Expense of columns 1 and 1	vided by sum thers) line 21) EXPENSE COMPUT and 25 for all therapy or sum	of columns TATION - PRO others) n of lines 3	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all	0.00 0 129,009 0 0 0 0	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trainctotal salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,	n line 2, make no lines 21-23. ainees (line 17 d line 9 for all o ees (line 2 times VANCE AND TRAVEL I sum of lines 24 for respiratory travel expense a Expense of columns 1 and 1 line 12)	entries on li vided by sum thers) line 21) EXPENSE COMPUT and 25 for all therapy or sum t the provider	of columns TATION - PRO others) n of lines 3	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all	0.00 0 129,009 0 0 0	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns)	n line 2, make no lines 21-23. ainees (line 17 d line 9 for all o pees (line 2 times VANCE AND TRAVEL I sum of lines 24 for respiratory travel expense a Expense of columns 1 and 1 line 12) sum of lines 29 sum of lines	entries on li vided by sum thers) line 21) EXPENSE COMPUT and 25 for all therapy or sum t the provider 2, line 12) and 30 for all	of columns Of columns Others) of lines 3 r site (sum others)	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all of lines 26 and	0.00 0 129,009 0 0 0 0	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and Standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	n line 2, make no lines 21-23. ainees (line 17 d line 9 for all o ees (line 2 times VANCE AND TRAVEL I sum of lines 24 for respiratory travel expense a Expense of columns 1 and 1 line 12) sum of lines 29 sum of lines 2	entries on li vided by sum thers) line 21) EXPENSE COMPUT and 25 for all therapy or sun t the provider 2, line 12) and 30 for all 3 for respirat	of columns Of columns Others) of lines 3 r site (sum others)	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all of lines 26 and	0.00 0 129,009 0 0 0 0 0 0	21. 00 22. 00 23. 00 24. 00 25. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns)	n line 2, make no lines 21-23. ainees (line 17 d line 9 for all o ees (line 2 times MANCE AND TRAVEL I sum of lines 24 for respiratory travel expense a Expense of columns 1 and 1 line 12) sum of lines 29 is 1 and 2, line 11 expense (line 2)	entries on li vided by sum thers) line 21) EXPENSE COMPUT and 25 for all therapy or sun t the provider 2, line 12) and 30 for all 3 for respirat 3)	of columns of columns others) of ines 3 r site (sum others) tory therapy	22 and enter on 1 and 2, line 9 OVIDER SITE 3 and 4 for all of lines 26 and	0.00 0 129,009 0 0 0 0	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00

6. 00	Number of unduplicated offsite visits - there assistant and on which supervisor and/or the		ő	6. 00			
	instructions)	aprist was not p	present during	the visit(s))	(366		
7.00	Standard travel expense rate					5. 51	7. 00
8. 00	Optional travel expense rate per mile	6 .	T		A: 1	0.00	8. 00
		Supervi sors 1.00	Therapi sts 2.00	Assi stants 3.00	4. 00	Trai nees 5. 00	
9. 00	Total hours worked	0.00	1, 667. 00		0.00		9. 00
10.00	AHSEA (see instructions)	0. 00	77. 39		0.00	l	10. 00
11. 00	Standard travel allowance (columns 1 and 2,	38. 70	38. 70	0.00			11. 00
	one-half of column 2, line 10; column 3,						
12. 00	one-half of column 3, line 10) Number of travel hours (provider site)	0	0	0			12. 00
12. 00	Number of travel hours (offsite)	0	0	0			12.00
13. 00	Number of miles driven (provider site)	0	0	-			13. 00
13. 01	Number of miles driven (offsite)	0	0	0			13. 01
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14. 00	Supervisors (column 1, line 9 times column 1,	line 10)				0	14. 00
15. 00	Therapists (column 2, line 9 times column 2,					129, 009	1
16. 00	Assistants (column 3, line 9 times column 3,					0	1
17. 00	Subtotal allowance amount (sum of lines 14 ar	nd 15 for respi	ratory therapy	or lines 14-16	for all	129, 009	17. 00
	others)	>				_	
18. 00	Aides (column 4, line 9 times column 4, line					0	18.00
19. 00 20. 00	Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17-19 fo		therany or lin	as 17 and 18 fo	r all others)	0 129, 009	19. 00 20. 00
20.00	If the sum of columns 1 and 2 for respiratory						20.00
	occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete	lines 21-23.					
21. 00	Weighted average rate excluding aides and tra			m of columns 1	and 2, line 9	0.00	21. 00
22.00	for respiratory therapy or columns 1 thru 3,						22.00
22. 00 23. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions)	ees (line 2 time	es iine 21)			129, 009	22. 00
23.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMP	UTATION - PROVI	DER SLITE	127,007	23.00
	Standard Travel Allowance						1
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				4 6!!	0	26. 00
27. 00	Standard travel expense (line 7 times line 3 others)	for respirator	y therapy or s	um of lines 3 a	nd 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					ı	
	Therapists (column 2, line 10 times the sum of		d 2, line 12)			0	
30.00	Assistants (column 3, line 10 times column 3,		0 and 20 fam a	ll othoro)		0 0	1
31. 00 32. 00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns				r sum of	0	31. 00 32. 00
32.00	columns 1-3, line 13 for all others)	3 I dild 2, IIIIC	15 TOT T CSPTT	atory therapy o	i Julii Oi	Ĭ	32.00
33. 00	Standard travel allowance and standard travel	expense (line	28)			0	33. 00
34. 00	Optional travel allowance and standard travel			,		0	
35. 00	Optional travel allowance and optional travel				50 OUTOU DE DD	0	35. 00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	INCE AND TRAVEL	EXPENSE COMPU	TATION - SERVIC	ES OUTSTDE PRO	OVIDER SITE	1
36. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.00
37. 00	Assistants (line 6 times column 3, line 11)					Ö	1
38. 00	Subtotal (sum of lines 36 and 37)					Ö	38. 00
39. 00	Standard travel expense (line 7 times the sur	n of lines 5 and	d 6)			0	39. 00
	Optional Travel Allowance and Optional Travel						
40. 00	Therapists (sum of columns 1 and 2, line 12.0		2, line 10)			0	
41.00	Assistants (column 3, line 12.01 times column	n 3, line 10)				0	
42. 00 43. 00	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur	n of columns 1	3 line 12 01\			0	1
45.00	Total Travel Allowance and Travel Expense - C				ina three line	l	, 43.00
	or 46, as appropriate.	2. 10 001 11 000	, 11p. 010 011		.5 00 11110	,,	
44. 00	Standard travel allowance and standard travel	expense (sum o	of lines 38 an	d 39 – see inst	ructions)	0	44. 00
45. 00	Optional travel allowance and standard travel	expense (sum o	of lines 39 an	d 42 – see inst	ructions)	0	45. 00

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151324	Peri od: From 01/01/2014 To 12/31/2014		pared:
					Physical Therapy	Cost	
						1. 00	
6. 00	Optional travel allowance and optional travel		of lines 42 ar	nd 43 - see in	nstructions)		46. 0
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
	PART V - OVERTIME COMPUTATION	1.00	2. 00	3. 00	4. 00	5. 00	
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. (0.00	0.00	47. 0
8. 00	Overtime rate (see instructions)	0. 00	0.00	0. (0.00		48.0
9. 00	Total overtime (including base and overtime	0. 00	0.00	0. (0.00		49. 0
	allowance) (multiply line 47 times line 48)						
0. 00	CALCULATION OF LIMIT Percentage of overtime hours by category	0. 00	0.00	0.0	0.00	0.00	50.0
	(divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)						
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	0.00	0.00	51.0
	DETERMINATION OF OVERTIME ALLOWANCE			1		1	
2. 00	Adjusted hourly salary equivalency amount (see instructions)	77. 39	0.00	0. (0.00		52. 0
3. 00	Overtime cost limitation (line 51 times line	0	O		0 0		53. 0
4. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.0
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply	0	C		0 0		55. 0
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	0	C		0 0	0	56. 0
	for all others.)					1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND FXCESS COST	AD.JUSTMENT			1. 00	
7. 00	Salary equivalency amount (from line 23)					129, 009	57.0
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63)	es (from lines	44, 45, or 46)		0 0 0 0 0 129, 009 100, 023	60. 0 61. 0 62. 0 63. 0 64. 0
	LINE 33 CALCULATION	-	,				
00. 01	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				others	0	100. 0 100. 0 100. 0
01. 01	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				others	0	101. 0 101. 0 101. 0
	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for a	III others			102.0
	Line 32 = line 8 times columns 1 and 2, line				umns 1-3. line		102. C
02.01	Zi ilo di ilimoo doi amilio i ana zi ilimo						

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 151324

					Т	o 12/31/2014	Date/Time Pre 12/21/2015 2:	
				CAPI TAL			1272172010 21	ο, <u>β</u>
		Cost Center Description	Net Expenses	RELATED COSTS NEW BLDG &	 EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		,	for Cost	FLXT	BENEFITS		& GENERAL	
			Allocation		DEPARTMENT			
			(from Wkst A col. 7)					
			0	1.00	4. 00	4A	5. 00	
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT	2, 007, 452	2, 007, 452				1. 00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT	3, 890, 338	l	1			4. 00
5.00	1	ADMINISTRATIVE & GENERAL	4, 670, 616			5, 423, 653		5. 00
7.00		OPERATION OF PLANT	1, 060, 766			1, 155, 851	216, 096	7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	109, 404 462, 191	30, 621 36, 245		157, 232 588, 491	29, 396 110, 023	8. 00 9. 00
10.00		DI ETARY	359, 846			439, 154	l	•
11.00		CAFETERI A	143, 866	1		216, 711	40, 516	
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	149, 318 31, 146	l ·		192, 721 35, 839	36, 031 6, 700	13. 00 14. 00
15. 00		PHARMACY	2, 205, 027	19, 088		2, 320, 913		15. 00
16. 00		MEDICAL RECORDS & LIBRARY	371, 240	l ·				16. 00
17. 00		SOCIAL SERVICE ENT ROUTINE SERVICE COST CENTERS	49, 810	1, 761	12, 002	63, 573	11, 885	17. 00
30. 00		ADULTS & PEDIATRICS	1, 674, 845	222, 336	376, 442	2, 273, 623	425, 072	30. 00
31. 00		INTENSIVE CARE UNIT	690, 592	1			162, 016	
41. 00 42. 00		SUBPROVI DER - I RF SUBPROVI DER	0	0		0	0 0	41. 00 42. 00
43. 00		NURSERY	132, 342	1, 988		164, 294	30, 716	
		LARY SERVICE COST CENTERS						
50. 00 52. 00		OPERATING ROOM DELIVERY ROOM & LABOR ROOM	2, 301, 605 13, 234	1			l	50. 00 52. 00
54. 00		RADI OLOGY-DI AGNOSTI C	2, 743, 910			3, 170, 610	l	
57. 00	05700	CT SCAN	0	0		0	0	57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	1, 743, 102	46, 660	176, 745	1, 966, 507	0 367, 654	59. 00 60. 00
60. 01	06001	BLOOD LABORATORY	0	0	0	0	0	60. 01
63.00		BLOOD STORING, PROCESSING & TRANS.	83, 979			87, 766	16, 409	63.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	1, 038, 534 685, 671	61, 317 45, 372		1, 308, 306 866, 508	l	65. 00 66. 00
66. 01		KV HEALTH PT	522, 688	1			146, 558	
67. 00		OCCUPATIONAL THERAPY	456, 893			593, 609	l	
67. 01 68. 00		KV HEALTH OT SPEECH PATHOLOGY	146, 178 143, 836	l ·		220, 821 186, 872	41, 284 34, 937	67. 01 68. 00
68. 01		KV HEALTH ST	108, 833	l ·		164, 416	l	68. 01
70. 00		ELECTROENCEPHALOGRAPHY	0	0	1	0	0	70. 00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT	184, 215 42, 657	21, 095 3, 257		205, 310 45, 914	38, 384 8, 584	
73. 00	1	DRUGS CHARGED TO PATTENT	42,037	l		45, 714	0, 384	73.00
		TIENT SERVICE COST CENTERS						
88. 00 88. 03		RURAL HEALTH CLINIC RURAL HEALTH CLINIC IV	278, 996 296, 701	0 50, 182	45, 121 45, 631	324, 117 392, 514		
89. 00	1	FEDERALLY QUALIFIED HEALTH CENTER	270, 701	0	45,051	372, 314	73, 304	89. 00
90.00		CLINIC	733, 671	84, 969		987, 385	184, 600	90. 00
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	1, 964, 638	84, 533	228, 912	2, 278, 083	425, 906	91. 00 92. 00
93. 00		FAMILY PRACTICE	0	0	0	0	0	
101 00		REI MBURSABLE COST CENTERS	1 47/ 222	F0 420	200 040	1 042 /10	244 (70	101 00
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	1, 476, 233	58, 438	308, 948	1, 843, 619	344, 679	101.00
116.00		HOSPI CE	417, 931			453, 657	84, 815	116. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	33, 392, 304	1, 782, 599	3, 670, 471	32, 947, 584	5, 145, 816	118. 00
190.00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4, 355	0	4, 355	814	190. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	1	0	0	192. 00
		RENSSELAER HEALTH CENTER	0	0	0	0		192. 01
		NONPALD WORKERS ALTERNACARE	482, 946	158, 348	112, 030	753, 324	l .	193. 00 194. 00
		DME EQUIPMENT	2, 789		0	2, 789		194. 01
		KV HEALTH CENTER	329, 364	46, 338		448, 572	83, 864	
		ST. JOE HEALTH CENTER FOUNDATION	51, 934 14, 170	l e	12, 489 0	64, 423 14, 170		194. 03 194. 04
194.05	07954	MEALS ON WHEELS	0	0	0	0		194. 05
194.06	07955	WATER LAB	74, 961	10, 491		98, 479		
194. 07 200. 00		ADVERTISING Cross Foot Adjustments	85, 217	5, 321	9, 451	99, 989 0	18, 694	194. 07 200. 00
200.00		Negative Cost Centers		0	0		0	200.00
			•	•		•	•	·

Health Financial Systems	JASPER COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B		
				From 01/01/2014 To 12/31/2014	Part I Date/Time Pre	pared:	
					12/21/2015 2:	09 pm	
		CAPITAL					
		RELATED COSTS					
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE		
	for Cost	FLXT	BENEFITS		& GENERAL		
	Allocation		DEPARTMENT				
	(from Wkst A						
	col . 7)						
	0	1. 00	4.00	4A	5. 00		
202.00 TOTAL (sum lines 118-201)	34, 433, 685	2, 007, 452	3, 890, 33	8 34, 433, 685	5, 423, 653	202. 00	

Provi der CCN: 151324 Peri od: Worksheet B From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	Date/Time Pre 12/21/2015 2: CAFETERIA	
	7. 00	LINEN SERVICE 8.00	9. 00	10. 00	11. 00	
GENERAL SERVI CE COST CENTERS	Ī					
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMI NI STRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	1, 371, 947 23, 394 27, 690 29, 195 25, 810 5, 830	0	726, 204 3, 863 2, 945 0	554, 315 O	285, 982 3, 489	1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	14, 583	0	0 0 5, 998	0	0 8, 564	14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	19, 748 1, 345		0	0	13, 513 1, 684	16. 00 17. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 O3000 ADULTS & PEDIATRICS	169, 863	80, 835	326, 842	283, 225	52, 249	30.00
31. 00 03100 I NTENSI VE CARE UNI T	10, 937	8, 522	18, 957	29, 558	16, 505	31. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0 1, 519	0 1, 881	0 3, 290	0	0 2, 891	42. 00 43. 00
ANCILLARY SERVICE COST CENTERS	1,517	1,001	3, 270		2,071	1 43.00
50. 00 05000 OPERATING ROOM	165, 940		0	0	15, 073	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 54.00 05400 RADIOLOGY-DIAGNOSTIC	3, 082 139, 233	190 14, 974	4, 387 57, 096	0	289 25, 752	52. 00 54. 00
57. 00 05700 CT SCAN	0	0	0	Ö	23, 732	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	o	0	o	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0 35, 647	0	27 424	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	35, 647	0	37, 624 0	0	23, 655 0	60. 00 60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	2, 893	0	0	O	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	46, 845		26, 858	0	24, 059	65. 00
66. 00 06600 PHYSI CAL THERAPY 66. 01 06601 KV HEALTH PT	34, 664 117, 416	17, 640	16, 160 0	0	13, 560 0	66. 00 66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	23, 813	ő	11, 101	Ö	10, 565	•
67. 01 06701 KV HEALTH OT	33, 550	o	0	0	0	67. 01
68. 00 06800 SPEECH PATHOLOGY	7, 494	0	3, 492	0	3, 326	68.00
68.01 06801 KV HEALTH ST 70.00 07000 ELECTROENCEPHALOGRAPHY	24, 985 0	0	0	0	0	68. 01 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 117	Ö	0	Ö	1, 468	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 488	0	0	0	0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	0	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	38, 338	0	0	0	0	88. 03
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0 64, 915	0 11, 723	0	0 ₁ 6, 637	0 16, 985	89. 00 90. 00
91. 00 09100 EMERGENCY	64, 582		53, 179	0, 037	28, 970	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
93. 00 04040 FAMILY PRACTICE OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	93. 00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	44, 646	0	28, 425	0	0	101. 00
116. 00 11600 HOSPI CE	3, 602	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 200, 164	180, 849	600, 217	319, 420	262, 597	118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 327		3, 581	٥	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	3,327	0	3, 361	0		192.00
192.01 19201 RENSSELAER HEALTH CENTER	0	0	0	0	0	192. 01
193. 00 19300 NONPALD WORKERS	120.075	0	117 007	0		193. 00
194. 00 07950 ALTERNACARE 194. 01 07951 DME EQUI PMENT	120, 975 0	29, 173 0	117, 997 0	234, 895 0		194. 00 194. 01
194. 02 07952 KV HEALTH CENTER	35, 401	o	0	O		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	0		194. 04 194. 05
194.06 07955 WATER LAB	8, 015	ol	4, 409	ol		194. 05
194. 07 07956 ADVERTI SI NG	4, 065	1	0	o		194. 07
200.00 Cross Foot Adjustments					0	200. 00 201. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	1, 371, 947	210, 022	726, 204	554, 315	285, 982	
		•	,	'		

Provi der CCN: 151324 Peri od: Worksheet B From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

			To	12/31/2014	Date/Time Pre 12/21/2015 2:	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	э рііі
	ADMI NI STRATI ON	SERVICES &		RECORDS &		
	13.00	SUPPLY 14.00	15. 00	16. 00	17. 00	
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	10.00	17.00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING						8. 00 9. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9. 00 10. 00
11. 00 01100 CAFETERI A						11. 00
13. 00 01300 NURSING ADMINISTRATION	238, 071					13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	42, 539				14.00
15. 00 01500 PHARMACY	0	0	2, 783, 971			15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	601, 827	70 407	16. 00
17. 00 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	U	0	U	78, 487	17. 00
30. 00 03000 ADULTS & PEDIATRICS	77, 655	O	0	185, 831	72, 726	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	24, 531	Ō	0	0	5, 761	31. 00
41. 00 04100 SUBPROVI DER - RF	0	o	0	o	0	41. 00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY	4, 296	0	0	1, 678	0	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	22, 402	O	0	55, 756	0	50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	429	0	0	170	0	52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	38, 275	Ö	0	103, 297	0	54. 00
57.00 05700 CT SCAN	0	0	0	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	o	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 06000 LABORATORY	0	0	0	16, 123	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 65.00 06500 RESPIRATORY THERAPY		0	0	0	0	63. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	o	0	66. 00
66. 01 06601 KV HEALTH PT	o	o	0	o	0	66. 01
67.00 06700 OCCUPATIONAL THERAPY	0	o	0	o	0	67. 00
67. 01 06701 KV HEALTH OT	0	0	0	0	0	67. 01
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
68. 01 06801 KV HEALTH ST 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	68. 01 70. 00
71. 00 07100 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 181	42, 539	0	0	0	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	o	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	o	2, 783, 971	o	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
88.03 08801 RURAL HEALTH CLINIC IV 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 03 89. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90.00 09000 CLINIC	25, 245	0	0	168, 379	0	90.00
91. 00 09100 EMERGENCY	43, 057	ő	0	70, 593	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00 04040 FAMILY PRACTICE	0	0	0	0	0	93. 00
OTHER REIMBURSABLE COST CENTERS	1	ما	-	ام		
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
116. 00 11600 HOSPI CE	O	O	0	ol	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	238, 071	42, 539		601, 827	78, 487	
NONREI MBURSABLE COST CENTERS		,,	=//	22.7.22.1		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSI CLANS' 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 NONPALD WORKERS 194. 00 07950 ALTERNACARE	0	0	0	0		193.00
194. 01 07950 ALTERNACARE 194. 01 07951 DME_EQUI PMENT		O O	0	O O		194. 00 194. 01
194. 02 07952 KV HEALTH CENTER		ol Ol	0	ol Ol		194. 01
194. 03 07957 ST. JOE HEALTH CENTER		o	Ö	o		194. 03
194. 04 07953 FOUNDATI ON	0	o	0	o		194. 04
194. 05 07954 MEALS ON WHEELS	0	o	0	O		194. 05
194. 06 07955 WATER LAB	0	0	0	0		194. 06
194.07 07956 ADVERTISING 200.00 Cross Foot Adjustments		O	O	O	0	194. 07 200. 00
201.00 Negative Cost Centers		n	n	n	n	200.00
202. 00 TOTAL (sum lines 118-201)	238, 071	42, 539	2, 783, 971	601, 827	78, 487	
	·	·	'	·		

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CCN: 151324	Peri od:	Worksheet B
				From 01/01/2014 To 12/31/2014	Part I Date/Time Prepared:
Cost Center Description	Subtotal	Intern &	Total		12/21/2015 2: 09 pm
		Residents Cost			
		& Post Stepdown			
		Adjustments			
OFFICE ASSESSMENT OF ASSESSMEN	24. 00	25. 00	26. 00		
1.00 OO100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL					5. 00
7.00 00700 0PERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON					11. 00 13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY					14. 00
15. 00 01500 PHARMACY					15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE					16. 00 17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					17.00
30. 00 03000 ADULTS & PEDIATRICS	3, 947, 921	0	3, 947, 92		30.00
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF	1, 143, 378	0	1, 143, 3	78 O	31. 00 41. 00
42. 00 04200 SUBPROVI DER	0	0		0	42. 00
43. 00 04300 NURSERY	210, 565	0	210, 5	55	43. 00
ANCILLARY SERVICE COST CENTERS	2 444 246	0	2 444 2	4.4	F0 00
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 444, 346 32, 598	0	3, 444, 3, 32, 5		50. 00 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 142, 006	0	4, 142, 00		54. 00
57. 00 05700 CT SCAN	0	0		0	57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION	0			0	58. 00 59. 00
60. 00 06000 LABORATORY	2, 447, 210	Ö	2, 447, 2	10	60.00
60. 01 06001 BLOOD LABORATORY	0	0	407.0	0	60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 65. 00 06500 RESPIRATORY THERAPY	107, 068 1, 653, 622	0	107, 00 1, 653, 63		63. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 110, 533	Ö	1, 110, 5		66. 00
66. 01 06601 KV HEALTH PT	1, 047, 885	0	1, 047, 88		66. 01
67. 00 06700 0CCUPATI ONAL THERAPY 67. 01 06701 KV HEALTH OT	750, 068 295, 655		750, 00 295, 6!		67. 00 67. 01
68. 00 06800 SPEECH PATHOLOGY	236, 121	Ö	236, 1		68. 00
68. 01 06801 KV HEALTH ST	220, 140	0	220, 1		68. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	305, 999	0	305, 9	0	70. 00 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	56, 986	Ö	56, 98		72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	2, 783, 971	0	2, 783, 9	71	73. 00
88. 00 08800 RURAL HEALTH CLINIC	384, 713	0	384, 7	13	88. 00
88. 03 08801 RURAL HEALTH CLINIC IV	504, 236	Ö	504, 2		88. 03
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	4.4/5.0	0	89.00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	1, 465, 869 2, 990, 191		1, 465, 86 2, 990, 19		90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,,,0,.,.	Ö	2, ,,,,,		92. 00
93. 00 04040 FAMILY PRACTICE	0	0		0	93. 00
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY	2, 261, 369	0	2, 261, 3	59	101. 00
SPECIAL PURPOSE COST CENTERS					
116. 00 11600 HOSPICE 118. 00 SUBTOTALS (SUM OF LINES 1-117)	542, 074 32, 084, 524		542, 0 ³ 32, 084, 5		116. 00 118. 00
NONREI MBURSABLE COST CENTERS	32,004,324	<u> </u>	32,004,3	<u>- T</u>	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12, 077	0	12, 0	77	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 NONPALD WORKERS	0	0		Ö	193. 00
194. 00 07950 ALTERNACARE	1, 417, 536	0	1, 417, 5		194. 00
194. 01 07951 DME EQUIPMENT 194. 02 07952 KV HEALTH CENTER	3, 310 567, 837		3, 3 ⁻ 567, 8:		194. 01 194. 02
194. 03 07957 ST. JOE HEALTH CENTER	76, 467		76, 40		194. 03
194. 04 07953 FOUNDATI ON	16, 819	0	16, 8		194. 04
194. 05 07954 MEALS ON WHEELS 194. 06 07955 WATER LAB	131, 163		131, 10	U 53	194. 05 194. 06
194. 00 07955 WATER LAB 194. 07 07956 ADVERTI SI NG	123, 952		123, 9		194. 07
200.00 Cross Foot Adjustments	0	0		0	200. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	0 34, 433, 685	0	34, 433, 68	U 35	201. 00 202. 00
202. 00 10 mz (30m 111103 110-201)	1 54, 455, 665	١	54, 455, 00		1202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 151324

Count Center Description				1	0 12/31/2012	Date/lime Pre 12/21/2015 2:	
DEMBNIS SERVICE OF CENTERS 1.00	Cost Center Description	Assigned New Capital	RELATED COSTS NEW BLDG &	Subtotal	BENEFI TS	ADMI NI STRATI VE	
1.00			1.00	2A	4. 00	5. 00	
4.00 DOGOD LARL DYPE EMBELT IS DEPARTMENT 0 0 0 0 1 1 2.50 DOGOD CONTROL OF PLANT 0 33, 336 33, 336 6 176, 338 DOGOD CONTROL OF PLANT 0 33, 336 33, 336 6 176, 338 DOGOD CONTROL OF PLANT 0 33, 336 33, 336 6 176, 338 DOGOD CONTROL OF PLANT 0 33, 336 33, 336 6 76, 70 DOGOD CONTROL OF PLANT 0 33, 326 33, 336 6 76, 70 DOGOD CONTROL OF PLANT 0 33, 326 33, 338 0 1, 377 DOGOD CONTROL OF PLANT 0 33, 326 33, 338 0 1, 377 DOGOD CONTROL OF PLANT 0 33, 326 33, 338 0 1, 377 DOGOD CONTROL OF PLANT 0 33, 326 33, 338 0 1, 377 DOGOD CONTROL OF PLANT 0 1, 611 DOGOD CONTROL OF PLANT 0 1, 612 DOGOD CONTROL OF PLANT				I			1 00
30.00 30000 ADULT S R PEDIATRICS 0 222, 336 222, 336 0 13, 821 30, 00 41.00 41.00 0 0 0 0 0 0 0 0 0	4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY 17.00 01700 SOCIAL SERVICE	0 0 0 0 0 0 0	35, 336 30, 621 36, 245 38, 214 33, 783 7, 631 0 19, 088 25, 848	35, 336 30, 621 36, 245 38, 214 33, 783 7, 631 0 19, 088 25, 848	(((7, 026 956 3, 577 2, 670 1, 317 0 1, 172 218 0 24, 109 2, 912	4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
31.00			222 224	222 224	,	12 021	20.00
50.00	31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0 0	14, 316 0 0	14, 316 0 0	(5, 268 0 0	31. 00 41. 00 42. 00
54.00 05400 RADIOLOGY-DIAGNOSTIC 0 182, 246 0 19, 263 54.00 05.00	50. 00 05000 OPERATI NG ROOM	0	217, 203	217, 203	(16, 229	50. 00
60.01	54. 00 05400 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE MAGING (MRI)	0		182, 246	((((19, 263 0 0	54. 00 57. 00 58. 00
63.00 06.300 06.000 STORI NG, PROCESSING & TRANS. 0 3,787 3,787 0 5.34 63.00		0	46, 660	46, 660	(
65.00 06500 RESPIRATORY THERAPY 0 61,317 61,317 0 7,953 65.00 66.01 06600 PMSYLCAL THERAPY 0 45,372 0 5,268 66.00 66.01 06600 RVS HEALTH PT 0 153,690 153,690 0 4,765 66.01 67.00 06700 OCCUPATIONAL THERAPY 0 31,170 31,170 0 3,609 67.00 67.01 06701 VX HEALTH OT 0 43,914 43,914 0 1,342 67.01 68.00 06800 SPEECH PATHOLOGY 0 9,809 9,809 0 1,136 68.00 0.00 0.00 0.00 0 0 0 0 0		0	0	0	(
66.00		0		1	(
67. 00 0-7		0			(
67.01 OA701 KV HEALTH OT		0			(66. 01
68. 00 0.6800 SPECEH PATHOLOGY 0 9,809 9,809 0 1,136 68. 00							
68.01 06801 KV HEALTH ST 0 32,704 32,704 0 999 68.01					(
10. 00 07000 CLECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0		0			(
72. 00 07200 MPL DEV CHARGED TO PATIENT 0 3, 257 3, 257 0 279 72. 00		0	0		(
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00					(
OUTPATT LENT SERVICE COST CENTERS SR. 00		•			(
88. 00 08800 RIVAL HEALTH CLINIC 0 0 0 0 0 0 1,970 88. 00 880 RIVAL HEALTH CLINIC IV 0 50,182 50,182 0 2,386 88. 03 890 REDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0	OUTPATIENT SERVICE COST CENTERS	0	0	0	(<u> </u>	73.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	88.00 08800 RURAL HEALTH CLINIC	•					
90. 00 09000 CLI NI C 0 84, 969 84, 969 0 6, 002 90. 00 91. 00 91. 00 91. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 93. 00 9	· · · · · · · · · · · · · · · · · · ·	0	50, 182	50, 182	(2,000	
91. 00 09100 BMERGENCY 0 09200 DSERVATI ON BEDS (NON-DISTINCT PART) 0 84,533 84,533 0 13,848 91. 00 92. 00 93. 00 04040 FAMILY PRACTI CE 0 0 0 0 0 0 0 93. 00 04040 FAMILY PRACTI CE 0 0 0 0 0 0 0 93. 00 04040 FAMILY PRACTI CE 0 0 0 0 0 0 0 0 0		0	U 84 969	84 969	(l .	
93. 00 04040 FAMI LY PRACTICE 0 0 0 0 0 0 93. 00 THER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 0 58, 438 58, 438 0 11, 207 SPECI AL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 4, 715 4, 715 0 2, 758 116. 00 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 1, 782, 599 0 167, 304 SUBTOTALS (SUM OF LI NES 1-117) 0 1, 782, 599 1, 782, 599 1, 782, 599 1, 782, 599 1, 782, 599 1, 782, 599 1, 782, 599 1, 782, 599 1, 782, 599 1, 782, 599 1, 782, 599 1, 782, 599 1, 782, 599 1, 782, 599 1, 782, 599 1, 782, 599 1, 782, 599 1, 782, 599		0					
OTHER REIMBURSABLE COST CENTERS O 0 58,438 58,438 O 11,207 101.00 10100 HOME HEALTH AGENCY O 58,438 58,438 O 11,207 101.00 SPECI AL PURPOSE COST CENTERS O 4,715 4,715 O 2,758 116.00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) O 1,782,599 1,782,599 O 167,304 118.00 NONREI MBURSABLE COST CENTERS O O 0 O O 0 O O 0 O O				0			
101. 00		0	0	0	(0	93.00
116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) O 1,782,599 1,782,599 O 167,304 118. 00 NONREI MBURSABLE COST CENTERS O 1,782,599 1,782,599 O 167,304 118. 00 O 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN O 4,355 4,355 O 26 190. 00 192. 00 192.00 192.00 192.00 192.00 192.01 19	101. 00 10100 HOME HEALTH AGENCY	0	58, 438	58, 438	(11, 207	101. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 0 1,782,599 1,782,599 0 167,304 118. 00		_					
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 192. 01 192. 01 192. 01 192. 01 192. 01 192. 01 192. 01 192. 01 193. 00 193.	118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	1, 782, 599	1, 782, 599	(167, 304	118. 00
192. 01 19201 RENSSELAER HEALTH CENTER 0 0 0 0 0 0 192. 01 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 194. 00 07950 ALTERNACARE 0 158, 348 158, 348 0 4, 579 194. 00 194. 01 07951 NOT PRIVATE NOT PRIVA		_	4, 355	4, 355	(
193.00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193.00 194.00 07950 ALTERNACARE 0 158, 348 158, 348 0 4, 579 194.00 194.01 07951 DME EQUI PMENT 0 0 0 0 0 0 0 17 194.01 194.02 07952 KV HEALTH CENTER 0 46, 338 46, 338 0 2, 727 194.02 194.03 07957 ST. JOE HEALTH CENTER 0 0 0 0 0 0 392 194.03 194.04 07953 FOUNDATI ON 194.05 07954 MEALS ON WHEELS 0 0 0 0 0 0 0 0 194.05 194.06 07955 WATER LAB 0 10, 491 10, 491 0 599 194.05 194.07 07956 ADVERTI SI NG 100.00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		-	0	Ö	(
194. 01 07951 DME EQUI PMENT 0 0 0 17 194. 01 194. 02 07952 KV HEALTH CENTER 0 46, 338 46, 338 0 2, 727 194. 02 194. 03 07957 ST. JOE HEALTH CENTER 0 0 0 0 392 194. 03 194. 04 07953 FOUNDATI ON 0 0 0 0 86 194. 04 194. 05 07954 MEALS ON WHEELS 0 0 0 0 0 194. 05 194. 06 07955 WATER LAB 0 10, 491 10, 491 0 599 194. 06 194. 07 07956 ADVERTI SI NG 0 5, 321 5, 321 0 608 194. 07 200. 00 Cross Foot Adjustments 0 0 0 0 0 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00	193. 00 19300 NONPALD WORKERS	0	0	0	(
194. 02 07952 KV HEALTH CENTER 0 46, 338 46, 338 0 2, 727 194. 02 194. 03 07957 ST. JOE HEALTH CENTER 0 0 0 0 392 194. 03 194. 04 07953 FOUNDATI ON 0 0 0 0 86 194. 04 194. 05 07954 MEALS ON WHEELS 0 0 0 0 0 194. 05 194. 06 07955 WATER LAB 0 10, 491 0 599 194. 06 194. 07 07956 ADVERTI SI NG 0 5, 321 0 608 194. 07 200. 00 Cross Foot Adj ustments 0 0 0 0 0 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 0		0	158, 348	158, 348	(
194. 03 07957 ST. JOE HEALTH CENTER 0 0 0 0 0 392 194. 03 194. 04 194. 05 07953 FOUNDATI ON 0 0 0 0 0 0 0 194. 05 194. 06 07955 WATER LAB 0 10, 491 10, 491 0 599 194. 06 194. 07 07956 ADVERTI SI NG 0 5, 321 5, 321 0 608 194. 07 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0 46 338	46 338	(
194. 04 07953 FOUNDATION 0 0 0 0 0 86 194. 04 194. 05 107954 MEALS ON WHEELS 0 0 0 0 0 0 194. 05 194. 06 1955 WATER LAB 0 10, 491 10, 491 0 599 194. 06 194. 07 07956 ADVERTISING 0 5, 321 5, 321 0 608 194. 07 194. 07 194. 08 194. 09 194. 0	194. 03 07957 ST. JOE HEALTH CENTER		70, 338	10, 330			
194. 06 07955 WATER LAB 0 10, 491 10, 491 0 599 194. 06 194. 07 07956 ADVERTISING 0 5, 321 5, 321 0 608 194. 07 200. 00 Cross Foot Adjustments 0 0 0 0 0 201. 00	194. 04 07953 FOUNDATI ON	0	0	0	(86	194. 04
194. 07 07956 ADVERTI SI NG 0 5, 321 0 608 194. 07 200. 00 201. 00 Cross Foot Adjustments 0 0 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 201. 00		0	10 401	10 401	(
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00					(
			3,321		Ì		200. 00
202.00 TOTAL (SUM TITNES 178-201) 0 2,007,452 2,007,452 0 176,338 202.00			0	0 227 27	(
	ZUZ. UU TUTAL (SUM TINES TI8-201)	0	2,007,452	2,007,452	1	1/6, 338	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151324 Period: Worksheet B From 01/01/2014 Part II To 12/31/2014 Date/Time Prepared:

12/21/2015 2:09 pm

Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A **PLANT** LINEN SERVICE 9.00 10.00 11.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 42, 362 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 722 32, 299 8.00 00900 HOUSEKEEPI NG 9.00 855 40, 677 9.00 42, 001 10.00 01000 DI ETARY 901 0 10.00 216 01100 CAFETERI A 11.00 797 C 165 36, 062 11.00 01300 NURSING ADMINISTRATION 180 440 13.00 13.00 C 14 00 01400 CENTRAL SERVICES & SUPPLY 0 C 0 Ω 14.00 01500 PHARMACY 1, 080 0 15.00 15 00 450 C 336 01600 MEDICAL RECORDS & LIBRARY 1, 704 16.00 610 C 0 16.00 17.00 01700 SOCIAL SERVICE 42 212 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 30.00 21, 460 5.247 12.431 18.308 6.589 31.00 03100 INTENSIVE CARE UNIT 338 1, 311 1,062 2, 240 2,081 31.00 04100 SUBPROVI DER - I RF 41.00 0 C 0 41.00 04200 SUBPROVI DER 42.00 0 0 0 42.00 C 0 04300 NURSERY 43.00 47 289 184 0 365 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 5, 124 2, 508 C 0 1, 901 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 95 29 246 36 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4.299 2, 303 3, 198 3, 247 54.00 57.00 05700 CT SCAN 0 C 0 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 0 58.00 0 05900 CARDIAC CATHETERIZATION 59 00 Ω C \cap Λ 59 00 0 60.00 06000 LABORATORY 1, 101 C 2, 107 2, 983 60.00 06001 BLOOD LABORATORY 60.01 0 0 0 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 89 63.00 C 0 0 63.00 06500 RESPIRATORY THERAPY 65.00 1.446 455 1,504 3,034 65.00 1, 710 66.00 06600 PHYSI CAL THERAPY 1,070 2,713 905 66.00 06601 KV HEALTH PT 66.01 3,625 C 0 0 66.01 67 00 06700 OCCUPATIONAL THERAPY 622 1, 332 67 00 735 C 06701 KV HEALTH OT 67.01 1,036 C \cap Ω 67.01 06800 SPEECH PATHOLOGY 0 419 68.00 68.00 231 C 196 0 68.01 06801 KV HEALTH ST 771 0 68.01 0 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 498 0 0 0 185 71.00 72.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 77 0 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS O 0 73 00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 0 O 0 88.03 08801 RURAL HEALTH CLINIC IV 1, 184 0 0 o 0 88.03 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 0 89 00 C 0 0 90.00 09000 CLI NI C 2,004 1,803 0 503 2, 142 90.00 91.00 09100 EMERGENCY 1, 994 3.971 2.979 0 3,653 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 04040 FAMILY PRACTICE 93.00 93.00 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 1, 379 0 1, 592 0 0 101, 00 SPECIAL PURPOSE COST CENTERS 116.00 11600 HOSPI CE 111 0 116, 00 SUBTOTALS (SUM OF LINES 1-117) 27, 813 33, 620 24, 203 33, 113 118. 00 37,058 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 103 201 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 C 0 0 192, 00 192. 01 19201 RENSSELAER HEALTH CENTER 0 0 0 0 192. 01 0 193. 00 19300 NONPALD WORKERS 0 193.00 194. 00 07950 ALTERNACARE 2, 564 194. 00 3,735 4.486 6,609 17, 798 194. 01 07951 DME EQUIPMENT 0 0 0 194. 01 C 194. 02 07952 KV HEALTH CENTER 1,093 0 0 0 194. 02 0 194.03 07957 ST. JOE HEALTH CENTER 0 194. 03 0 0 0 194. 04 07953 FOUNDATI ON 0 C 0 0 0 194, 04 194.05 07954 MEALS ON WHEELS 0 194. 05 C 194.06 07955 WATER LAB 247 0 233 194. 06 247 194. 07 07956 ADVERTI SI NG 152 194. 07 126 C 200.00 Cross Foot Adjustments 200. 00 0 201.00 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201) 42.362 32, 299 40.677 42,001 36, 062 202. 00

| Peri od: | Worksheet B | From 01/01/2014 | Part | I | To 12/31/2014 | Date/Time Prepared: | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151324

			To	12/31/2014	Date/Time Pre 12/21/2015 2:	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	O7 piii
	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 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	1					8.00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
13.00 01300 NURSING ADMINISTRATION	9, 423					13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	218	25 242			14.00
15. 00 01500 PHARMACY	0	0	35, 063	21 074		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	0	0	31, 074	2, 401	16. 00 17. 00
I NPATIENT ROUTINE SERVICE COST CENTERS	9		<u> </u>		2, 401	17.00
30. 00 03000 ADULTS & PEDI ATRI CS	3, 074	0	0	9, 594	2, 225	30.00
31.00 03100 INTENSIVE CARE UNIT	971	O	0	O	176	31. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0	0	41. 00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY	170	0	0	87	0	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	887	O	0	2, 879	0	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	17	0	0	2,079	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 515	Ö	0	5, 334	0	54.00
57. 00 05700 CT SCAN	0	o	0	0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	О	0	o	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 06000 LABORATORY	0	0	0	832	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		0	0	0	0	65. 00 66. 00
66. 01 06601 KV HEALTH PT		0	0	0	0	66. 01
67. 00 06700 OCCUPATI ONAL THERAPY		ő	0	ő	0	67. 00
67. 01 06701 KV HEALTH OT	O	Ō	0	ō	0	67. 01
68.00 06800 SPEECH PATHOLOGY	0	O	0	o	0	68. 00
68. 01 06801 KV HEALTH ST	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 PATIENTS	86	218	0	0	0	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENT 73.00 O7300 DRUGS CHARGED TO PATIENTS	0 0	0	35, 063	0	0	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS	9		33, 003		0	73.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
88.03 08801 RURAL HEALTH CLINIC IV	0	O	0	o	0	88. 03
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 09000 CLI NI C	999	0	0	8, 694	0	90.00
91. 00 09100 EMERGENCY	1, 704	0	O	3, 645	0	
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 93.00 04040 FAMILY PRACTICE	0	0	0	0	0	92. 00 93. 00
OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>	0	73.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 H0SPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	9, 423	218	35, 063	31, 074	2, 401	118. 00
NONREI MBURSABLE COST CENTERS		ما		ما		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 RENSSELAER HEALTH CENTER	0	0	0	0		192. 00 192. 01
193. 00 19300 NONPALD WORKERS		0	0	0		193. 00
194. 00 07950 ALTERNACARE	0	o	0	o		194. 00
194. 01 07951 DME EQUIPMENT	0	0	0	o	0	194. 01
194.02 07952 KV HEALTH CENTER	0	0	0	0		194. 02
194.03 07957 ST. JOE HEALTH CENTER	0	0	0	0		194. 03
194. 04 07953 FOUNDATION	0	0	0	0		194. 04
194. 05 07954 MEALS ON WHEELS 194. 06 07955 WATER LAB		0	0	0		194. 05 194. 06
194. 06 07955 WATER LAB 194. 07 07956 ADVERTI SI NG		ol Ol	0	Ol Ol		194. 06
200.00 Cross Foot Adjustments		Ĭ	٩	Y		200. 00
201.00 Negative Cost Centers	0	o	0	o		201. 00
202.00 TOTAL (sum lines 118-201)	9, 423	218	35, 063	31, 074	2, 401	202. 00

| Peri od: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 151324

				To 12/31/2014 Date/Time F 12/21/2015	
Cost Center Description	Subtotal	Intern &	Total	1272172013	2.07 piii
		Residents Cost			
		& Post Stepdown			
		Adjustments			
ASSUSPENDENCE AND ASSUSPENDENC	24. 00	25. 00	26. 00		
1.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	1	T T			1.00
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00 00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00 00700 OPERATION OF PLANT					7. 00
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG					8. 00 9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY					14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00 01700 SOCIAL SERVICE					17. 00
INPATIENT ROUTINE SERVICE COST CENTERS			045.00	1	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	315, 085 27, 763	1	315, 08 27, 76		30. 00 31. 00
41. 00 04100 SUBPROVI DER - I RF	27,703	1		0	41. 00
42. 00 04200 SUBPROVI DER	C	1		0	42. 00
43. 00 04300 NURSERY	4, 129	0	4, 12	.9	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	246, 731	O	246, 73	21	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	4, 588	1 1	240, 73 4, 58		52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	221, 405	1 1	221, 40		54. 00
57. 00 05700 CT SCAN	C	1		0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	C			0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	65, 637	, 0	65, 63	57	59. 00 60. 00
60. 01 06001 BLOOD LABORATORY	00,007	1		Ö	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	4, 410	1 1	4, 41		63. 00
65. 00 06500 RESPIRATORY THERAPY	75, 709	1	75, 70		65. 00
66. 00 06600 PHYSI CAL THERAPY 66. 01 06601 KV HEALTH PT	57, 038 162, 080	1	57, 03 162, 08		66. 00 66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	37, 468	1	37, 46		67. 00
67. 01 06701 KV HEALTH OT	46, 292	1	46, 29		67. 01
68. 00 06800 SPEECH PATHOLOGY	11, 791	1	11, 79		68. 00
68. 01 06801 KV HEALTH ST 70. 00 07000 ELECTROENCEPHALOGRAPHY	34, 474	1	34, 47	0	68. 01 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	23, 330	1 -1	23, 33	٩	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 613	0	3, 61	3	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	35, 063	8 0	35, 06	03	73. 00
0UTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	1, 970	0	1, 97	ro	88. 00
88. 03 08801 RURAL HEALTH CLINIC IV	53, 752	1 1	53, 75		88. 03
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0		0	89. 00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	107, 116		107, 11		90.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	116, 327		116, 32		91. 00 92. 00
93. 00 04040 FAMI LY PRACTI CE	C	o o		0	93. 00
OTHER REIMBURSABLE COST CENTERS					
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	72, 616	0	72, 61	6	101. 00
116. 00 11600 HOSPI CE	7, 584	l ol	7, 58	34	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 735, 971	1	1, 735, 97		118. 00
NONRE MBURSABLE COST CENTERS					
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 685	0	4, 68	35	190. 00 192. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 RENSSELAER HEALTH CENTER					192. 00
193. 00 19300 NONPAI D WORKERS	C	o		0	193. 00
194. 00 07950 ALTERNACARE	198, 119	1	198, 11		194. 00
194. 01 07951 DME EQUI PMENT	17	1	50 15		194. 01
194. 02 07952 KV HEALTH CENTER 194. 03 07957 ST. JOE HEALTH CENTER	50, 158 392	1	50, 15 39		194. 02 194. 03
194. 04 07953 FOUNDATION	86	1		36	194. 04
194.05 07954 MEALS ON WHEELS	C	0		0	194. 05
194. 06 07955 WATER LAB	11, 817	1	11, 81		194. 06
194.07 07956 ADVERTISING 200.00 Cross Foot Adjustments	6, 207	1	6, 20	07	194. 07 200. 00
201.00 Negative Cost Centers				o o	201. 00
202.00 TOTAL (sum lines 118-201)	2, 007, 452	2 0	2, 007, 45	52	202. 00

	Financial Systems	JASPER COUNT				u of Form CMS-	
COST A	NLLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2014 o 12/31/2014	Worksheet B-1 Date/Time Pre 12/21/2015 2:	pared:
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4. 00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	106, 009					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	16, 133, 732		00 040 000		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	9, 312	2, 391, 664				5. 00
7.00	00700 OPERATION OF PLANT	1, 866	247, 786	1	.,,	94, 831	1
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	1, 617 1, 914	71, 358 373, 471	1		1, 617 1, 914	1
10.00	01000 DI ETARY	2, 018	170, 423	1		2, 018	1
11. 00	01100 CAFETERI A	1, 784	161, 997			1, 784	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	403	148, 350		/	403	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	19, 463	1		0	1
15.00	01500 PHARMACY	1, 008	401, 432	2 0	2, 320, 913	1, 008	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 365	339, 745			1, 365	
17. 00	01700 SOCIAL SERVICE	93	49, 773	0	63, 573	93	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1 44 -44			0.070 (0.0		
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	11, 741	1, 561, 150	1		11, 741	1
41. 00	04100 SUBPROVI DER – I RF	756 0	670, 518	0		756 0	1
42.00	04200 SUBPROVI DER		0			0	1
	04300 NURSERY	105	124, 263	1		105	
	ANCILLARY SERVICE COST CENTERS		.=., ===	-			1
50.00	05000 OPERATI NG ROOM	11, 470	625, 931	0	2, 669, 739	11, 470	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	213	12, 426			213	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	9, 624	1, 013, 779	0	3, 170, 610	9, 624	
57. 00	05700 CT SCAN	0	0	0	0	0	
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0	0		0	
60.00	06000 LABORATORY	2, 464	732, 985	1	1, 966, 507	2, 464	1
60. 00	06001 BLOOD LABORATORY	2, 404	/32, 7 65			2, 404	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	200	0			200	1
65. 00	06500 RESPI RATORY THERAPY	3, 238	864, 490	1		3, 238	1
66.00	06600 PHYSI CAL THERAPY	2, 396	561, 792	1			
66. 01	06601 KV HEALTH PT	8, 116	445, 953	0	783, 911	8, 116	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	1, 646	437, 711		,	1, 646	1
67. 01	06701 KV HEALTH OT	2, 319	127, 438	•		2, 319	1
68. 00	06800 SPEECH PATHOLOGY	518	137, 797			518	1
68. 01 70. 00	06801 KV HEALTH ST	1, 727	94, 881	0		1, 727	1
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 114	0			0 1 114	70.00
	07200 IMPL. DEV. CHARGED TO PATTENTS	172	0	1			72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	1			73. 00
	OUTPATIENT SERVICE COST CENTERS	, -,		,	1		
88. 00	08800 RURAL HEALTH CLINIC	0	187, 123			0	
	08801 RURAL HEALTH CLINIC IV	2, 650	189, 237				88. 03
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(00,007	0	-	0	
90.00	09000 CLI NI C 09100 EMERGENCY	4, 487 4, 464	699, 807	1	,	4, 487 4, 464	•
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 404	949, 326		2, 278, 083	4, 404	92.00
	04040 FAMILY PRACTICE	0	0	0	0	0	1
70.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		70.00
101.00	10100 HOME HEALTH AGENCY	3, 086	1, 281, 244	0	1, 843, 619	3, 086	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 HOSPI CE	249	128, 606				116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	94, 135	15, 221, 919	-5, 423, 653	27, 523, 931	82, 957	118. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	230	0	0	4, 355	230	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	1			192. 00
	19201 RENSSELAER HEALTH CENTER	o	0	Ö			192. 01
	19300 NONPALD WORKERS	0	0	0	0	0	193. 00
	07950 ALTERNACARE	8, 362	464, 603	1			194. 00
	07951 DME EQUI PMENT	0	0	0	-,		194. 01
	07952 KV HEALTH CENTER	2, 447	302, 199	1	448, 572		194. 02
	07957 ST. JOE HEALTH CENTER 07953 FOUNDATION	0	51, 794	0			194. 03 194. 04
	07953 FOUNDATION 07954 MEALS ON WHEELS		0	0	,		194. 04
	07955 WATER LAB	554	54, 023	1	98, 479		194. 05
	07956 ADVERTI SI NG	281	39, 194		99, 989		194. 07
200.00				1			200. 00
201.00	Negative Cost Centers			[201. 00
-							

Heal th Finar	ncial Systems	JASPER COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der	CCN: 151324	Peri od:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014		pared: 09 pm
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	NEW BLDG &		Reconciliation	on ADMI NI STRATI VE		
		FLXT	BENEFITS		& GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
			SALARI ES)				
		1.00	4.00	5A	5. 00	7. 00	
202.00	Cost to be allocated (per Wkst. B,	2, 007, 452	3, 890, 338		5, 423, 653	1, 371, 947	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	18. 936619	0. 241131		0. 186958	14. 467284	203. 00
204. 00	Cost to be allocated (per Wkst. B,		0		176, 338	42, 362	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000000		0. 006079	0. 446710	205.00
	11)						
·		•					-

In Lieu of Form CMS-2552-10 Health Financial Systems JASPER COUNTY HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 151324 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 12/21/2015 2:09 pm Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG LINEN SERVICE (HOURS OF (MEALS (MAN ADMI NI STRATI ON (DOLLAR SERVICE) SERVED) HOURS) VALUE) (MAN HOURS) 9.00 10.00 8.00 11.00 13.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 49, 804 8.00 8.00 00900 HOUSEKEEPI NG 9.00 162, 231 9 00 10.00 01000 DI ETARY 0 863 36, 082 10.00 11.00 01100 CAFETERI A 0 658 379, 216 11.00 0 01300 NURSING ADMINISTRATION 212, 402 13 00 C 0 4.626 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 14.00 15.00 01500 PHARMACY 0 1, 340 11, 356 0 15.00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 17, 919 16.00 0 01700 SOCIAL SERVICE 2, 233 17.00 O 0 17 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 19, 169 73, 015 18, 436 69, 281 69, 281 30.00 03100 INTENSIVE CARE UNIT 1, 924 31 00 2 021 4.235 21,886 21,886 31 00 41.00 04100 SUBPROVIDER - IRF 0 0 41.00 04200 SUBPROVI DER 0 0 42.00 42.00 C 0 43.00 04300 NURSERY 446 735 3,833 3, 833 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3,867 0 19, 987 19, 987 50.00 05200 DELIVERY ROOM & LABOR ROOM 980 52.00 45 383 383 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3.551 12, 755 0 34, 148 34, 148 54.00 05700 CT SCAN 0 57 00 57 00 0 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 59.00 06000 LABORATORY 0 60.00 0 8, 405 31, 367 60.00 0 06001 BLOOD LABORATORY 0 60.01 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 63.00 06500 RESPIRATORY THERAPY 65 00 701 6,000 31, 903 65.00 06600 PHYSI CAL THERAPY 4.183 3, 610 0 17, 981 66,00 0 66,00 0 66.01 06601 KV HEALTH PT 0 Λ 66.01 06700 OCCUPATIONAL THERAPY 0 67.00 2, 480 14,009 67.00 0 67.01 06701 KV HEALTH OT 0 67.01 0 06800 SPEECH PATHOLOGY 0 68.00 780 4, 410 0 68, 00 0 0 68.01 06801 KV HEALTH ST C 0 68.01 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 1, 946 1, 946 71.00 71.00 0 0 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 C Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 0 0 0 0 88.00 88.03 08801 RURAL HEALTH CLINIC IV 0 C 0 0 Ω 88.03 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 09000 CLI NI C 2,780 22, 523 22, 523 90.00 90.00 432 09100 EMERGENCY 91.00 91.00 6, 123 11,880 C 38.415 38, 415 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 04040 FAMILY PRACTICE 93.00 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 0 101. 00 101.00 10100 HOME HEALTH AGENCY 0 6, 350 0 0 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 116. 00 42, 886 348, 206 118 00 SUBTOTALS (SUM OF LINES 1-117) 134, 086 20. 792 212, 402 118, 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 800 C 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 C 0 0 0 192.00 192.01 19201 RENSSELAER HEALTH CENTER 0 192. 01 0 0 0 C 193. 00 19300 NONPALD WORKERS 0 193.00 194. 00 07950 ALTERNACARE 15, 290 0 194.00 6,918 26, 360 26, 961 194. 01 07951 DME EQUI PMENT 0 194. 01 194.02 07952 KV HEALTH CENTER 0 0 194 02 0 C 0 194. 03 07957 ST. JOE HEALTH CENTER 0 0 0 0 0 194. 03 194. 04 07953 FOUNDATI ON 0 0 194. 04 0 0 194.05 07954 MEALS ON WHEELS 0 0 0 194. 05 C 0 194.06 07955 WATER LAB 0 985 0 2, 452 0 194.06 194. 07 07956 ADVERTI SI NG 1, 597 0 194. 07 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201 00 202.00 Cost to be allocated (per Wkst. B, 210,022 726, 204 554, 315 285, 982 238, 071 202. 00 Part I)

Health Financial Systems	JASPER COUNTY HOSPITAL			In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2014 To 12/31/2014		
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)	4. 216971	4. 476358	15. 36264	6 0. 754140	1. 120851	203. 00
204.00 Cost to be allocated (per Wkst. B,	32, 299	40, 677	42, 00	1 36, 062	9, 423	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 648522	0. 250735	1. 16404	0. 095096	0. 044364	205. 00
11)						

	Financial Systems LOCATION - STATISTICAL BASIS	JASPER COUNT		CCN: 151324 F	In Lie Period:	w of Form CMS-2552-10 Worksheet B-1
CUST AL	LUCATION - STATISTICAL BASIS		Provi dei	F	rom 01/01/2014	
					o 12/31/2014	Date/Time Prepared: 12/21/2015 2:09 pm
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		SERVICES & SUPPLY	(100% ALLOCATION)	RECORDS & LI BRARY	(TIME	
		(100%	,	(TIME	SPENT)	
		ALLOCATION) 14.00	15. 00	SPENT) 16. 00	17. 00	
	GENERAL SERVICE COST CENTERS	14.00	13.00	10.00	17.00	
1	00100 NEW CAP REL COSTS-BLDG & FIXT					1. 00
	DO400 EMPLOYEE BENEFITS DEPARTMENT DO500 ADMINISTRATIVE & GENERAL					4.00
	00700 OPERATION OF PLANT					7. 00
	00800 LAUNDRY & LINEN SERVICE					8. 00
	DO900 HOUSEKEEPI NG D1000 DI ETARY					9.00
	D1100 CAFETERI A					11. 00
13.00	01300 NURSING ADMINISTRATION					13. 00
	01400 CENTRAL SERVICES & SUPPLY	100	100			14.00
	D1500 PHARMACY D1600 MEDICAL RECORDS & LIBRARY	0	100 0	138, 109		15. 00 16. 00
	01700 SOCIAL SERVICE	0	0	(
-	NPATIENT ROUTINE SERVICE COST CENTERS		0	42.44	202	20.00
	D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT	0	0	42, 645	202	30.00
	04100 SUBPROVI DER – I RF	0	0	Ċ	o	41. 00
	04200 SUBPROVI DER	0	0	(0	42.00
<u> </u>	D4300 NURSERY ANCILLARY SERVICE COST CENTERS	0	U	385	5 0	43. 00
	D5000 OPERATI NG ROOM	0	0	12, 795	0	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	0	0	39		
	D5400 RADI OLOGY-DI AGNOSTI C D5700 CT SCAN	0	0	23, 705	0	54. 00 57. 00
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	Ö	0		o o	58. 00
	D5900 CARDI AC CATHETERI ZATI ON	0	0	(0	59.00
	D6000 LABORATORY D6001 BLOOD_LABORATORY	0	0	3, 700	0	60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	l o	0		o o	63. 00
	06500 RESPI RATORY THERAPY	0	0	(0	65. 00
	D6600 PHYSICAL THERAPY D6601 KV HEALTH PT	0	0			66. 00 66. 01
	06700 OCCUPATI ONAL THERAPY	0	0		o o	67. 00
	06701 KV HEALTH OT	0	0	(0	67. 01
	D6800 SPEECH PATHOLOGY D6801 KV HEALTH ST	0	0	(68. 00 68. 01
	07000 ELECTROENCEPHALOGRAPHY	Ö	0		o o	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	100	0	(1	71.00
	D7200 IMPL. DEV. CHARGED TO PATIENT D7300 DRUGS CHARGED TO PATIENTS	0	0 100			72. 00 73. 00
-	OUTPATIENT SERVICE COST CENTERS	<u> </u>	100		,	73.00
	D8800 RURAL HEALTH CLINIC	0	0	(0	88.00
	D8801 RURAL HEALTH CLINIC IV D8900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(88. 03 89. 00
	09000 CLINIC	Ö	0	38, 640	o o	90.00
	D9100 EMERGENCY	0	0	16, 200	0	91.00
	D9200 OBSERVATION BEDS (NON-DISTINCT PART) D4040 FAMILY PRACTICE	0	0	(o	92. 00 93. 00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>			,,	70.00
	10100 HOME HEALTH AGENCY	0	0	(0	101. 00
	SPECIAL PURPOSE COST CENTERS 11600 HOSPICE	0	0		0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	100	100			
	NONREI MBURSABLE COST CENTERS		٥			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0			
	19201 RENSSELAER HEALTH CENTER	Ö	0		o o	192. 01
	19300 NONPALD WORKERS	0	0	(0	193. 00
	D7950 ALTERNACARE D7951 DME_EQUIPMENT	0	0	(194. 00 194. 01
194. 02 (07952 KV HEALTH CENTER	0	0	Č	o o	194. 02
	07957 ST. JOE HEALTH CENTER	0	0	(0	194. 03
	D7953 FOUNDATION D7954 MEALS ON WHEELS	0	0		0	194. 04 194. 05
194.06	07955 WATER LAB		0			194. 06
194. 07	D7956 ADVERTI SI NG	0	0	(o	194. 07
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers					200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	42, 539	2, 783, 971	601, 827	78, 487	202. 00
	Part I)			<u> </u>		<u> </u>

Health Finar	ncial Systems	JASPER COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014	Date/Time Pre 12/21/2015 2:	
	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)	425. 390000	27, 839. 710000	4. 35762	360. 032110		203. 00
204.00	Cost to be allocated (per Wkst. B,	218	35, 063	31, 07	4 2, 401		204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	2. 180000	350. 630000	0. 22499	6 11. 013761		205. 00
	11)						

					10 12/31/2014	12/21/2015 2:	
			Ti tl	e XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ATLENT ROUTINE SERVICE COST CENTERS						
•	00 ADULTS & PEDIATRICS	3, 947, 921		3, 947, 92	1 0	0	30. 00
•	OO INTENSIVE CARE UNIT	1, 143, 378		1, 143, 37	0	_	
	00 SUBPROVI DER – I RF	0			0	_	
	OO SUBPROVI DER	0			0		
	00 NURSERY	210, 565		210, 56	5 0	0	43. 00
	LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	3, 444, 346	l e	3, 444, 34			
	DO DELIVERY ROOM & LABOR ROOM	32, 598	l e	32, 59		-	
	OO RADI OLOGY-DI AGNOSTI C	4, 142, 006		4, 142, 00	6 0	-	
	OO CT SCAN	0			0	0	
	MAGNETIC RESONANCE IMAGING (MRI)	0			0	_	
	OO CARDI AC CATHETERI ZATI ON	0			0	0	
	DO LABORATORY	2, 447, 210		2, 447, 21	0	_	
	D1 BLOOD LABORATORY	0			0	0	60. 01
	DO BLOOD STORING, PROCESSING & TRANS.	107, 068	l	107, 06		_	
	OO RESPI RATORY THERAPY	1, 653, 622	0	.,,		0	65. 00
	OO PHYSI CAL THERAPY	1, 110, 533	l	1, 110, 53		_	66. 00
	O1 KV HEALTH PT	1, 047, 885	l .	1, 047, 88		0	66. 01
	OO OCCUPATIONAL THERAPY	750, 068	l	750, 06		_	67. 00
	01 KV HEALTH OT	295, 655	0	295, 65		ı	67. 01
	OO SPEECH PATHOLOGY	236, 121	0	236, 12		_	68. 00
	O1 KV HEALTH ST	220, 140	0	220, 14		0	68. 01
	OO ELECTROENCEPHALOGRAPHY	0			0	0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	305, 999	l e	305, 99		0	71. 00
	OO IMPL. DEV. CHARGED TO PATIENT	56, 986		56, 98			
	DO DRUGS CHARGED TO PATIENTS	2, 783, 971		2, 783, 97	1 0	0	73. 00
	PATIENT SERVICE COST CENTERS	201 710	ı			_	
•	OO RURAL HEALTH CLINIC	384, 713	ł	384, 71			
	21 RURAL HEALTH CLINIC IV	504, 236		504, 23		-	
	OO FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	07.00
	OO CLINIC	1, 465, 869		1, 465, 86		0	
•	OO EMERGENCY	2, 990, 191		2, 990, 19		0	
	OO OBSERVATION BEDS (NON-DISTINCT PART)	1, 023, 349	i e	1, 023, 34		0	
	FAMILY PRACTICE	0			0 0	0	93. 00
	R REIMBURSABLE COST CENTERS	2 2/1 2/0	Γ	2 2/1 2/			101 00
	OO HOME HEALTH AGENCY	2, 261, 369		2, 261, 36	9	0	101. 00
	CLAL PURPOSE COST CENTERS	E42.074		E40.03	4		11/ 00
116. 00 1160	•	542, 074	l	542, 07			116. 00
200.00	Subtotal (see instructions)	33, 107, 873	l				200. 00
201.00	Less Observation Beds	1, 023, 349		1, 023, 34			201. 00 202. 00
202. 00	Total (see instructions)	32, 084, 524	0	32, 084, 52	4 0	1	1202. UU

| Peri od: | Worksheet C | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: |

				'	0 12/31/2014	12/21/2015 2:	
			Ti tl	e XVIII	Hospi tal	Cost	<u>о, р</u>
			Charges		· ·		
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·		·	+ col. 7)	Ratio	I npati ent	
						Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	2, 869, 187		2, 869, 187		1	30. 00
31.00	03100 INTENSIVE CARE UNIT	651, 475		651, 475		1	31. 00
41. 00	04100 SUBPROVI DER - I RF	0		[C		1	41.00
42. 00	04200 SUBPROVI DER	0		C		i	42. 00
43. 00	04300 NURSERY	37, 845		37, 845			43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	1, 129, 246	3, 150, 445			0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	22, 550	15, 910			0. 000000	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	690, 447	7, 691, 595			0. 000000	1
57. 00	05700 CT SCAN	0	0	C		0. 000000	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C		0. 000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0.000000	0. 000000	1
60.00	06000 LABORATORY	1, 499, 342	7, 478, 667	8, 978, 009		0.000000	1
60. 01	06001 BLOOD LABORATORY	145 000	140.001	007.004	0.000000	0.000000	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	145, 800	142, 091		1	0.000000	1
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 431, 812	1, 450, 408			0. 000000 0. 000000	
66. 00 66. 01	06601 KV HEALTH PT	210, 505	1, 240, 669			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	124 520	1, 127, 417 237, 696			0. 000000	1
67. 00 67. 01	06700 OCCUPATIONAL THERAPY 06701 KV HEALTH OT	124, 520	237, 696 167, 687			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	30, 990	103, 514		1	0. 000000	
68. 01	06801 KV HEALTH ST	30, 990	110, 469		1	0. 000000	1
70. 00	07000 ELECTROENCEPHALOGRAPHY		110, 409		1	0. 000000	1
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	180, 875	627, 910	_		0. 000000	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	40, 415	87, 555		1	0. 000000	1
	07300 DRUGS CHARGED TO PATIENTS	1, 951, 357	4, 416, 150	·		0. 000000	1
70.00	OUTPATIENT SERVICE COST CENTERS	1, 701, 007	1, 110, 100	0,007,007	0. 107210	0.00000	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	340, 831	340, 831			88. 00
88. 03	08801 RURAL HEALTH CLINIC IV	0	352, 681			1	88. 03
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		1	1	89. 00
90.00	09000 CLI NI C	164, 632	2, 249, 808	2, 414, 440	0. 607126	0. 000000	90.00
91.00	09100 EMERGENCY	85, 144	2, 454, 125	2, 539, 269	1. 177579	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	256, 166	1, 386, 713	1, 642, 879	0. 622900	0.000000	92.00
93.00	04040 FAMILY PRACTICE	0	0	C	0. 000000	0. 000000	93.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	1, 360, 921	1, 360, 921			101. 00
	SPECIAL PURPOSE COST CENTERS						
	11600 H0SPI CE	0	966, 979		1	ı	116. 00
200.00		11, 522, 308	37, 160, 241	48, 682, 549		ı	200. 00
201.00						ı	201. 00
202.00	Total (see instructions)	11, 522, 308	37, 160, 241	48, 682, 549	1		202. 00

Health Financial Systems	JASPER COUNTY HOSPITAL	In Lieu of Form CMS-2552-1			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151324	Peri od: Worksheet C From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared: 12/21/2015 2:09 pm	-		

				12/21/2015 2:09 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30. 00
31.00 03100 INTENSIVE CARE UNIT				31.00
41. 00 04100 SUBPROVI DER - I RF				41.00
42. 00 04200 SUBPROVI DER				42. 00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
57. 00 05700 CT SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 000000			60.00
60. 01 06001 BLOOD LABORATORY	0. 000000			60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
				65. 00
65. 00 06500 RESPI RATORY THERAPY	0.000000			
66. 00 06600 PHYSI CAL THERAPY	0.000000			66. 00
66. 01 06601 KV HEALTH PT	0.000000			66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
67. 01 06701 KV HEALTH OT	0. 000000			67. 01
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
68. 01 06801 KV HEALTH ST	0. 000000			68. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPAȚI ENT SERVI CE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC				88. 00
88.03 08801 RURAL HEALTH CLINIC IV				88. 03
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
93. 00 04040 FAMILY PRACTICE	0. 000000			93. 00
OTHER REIMBURSABLE COST CENTERS	<u>'</u>			
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS	<u>'</u>			
116. 00 11600 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
	1			12.00

						12/21/2015 2:	09 pm
			Ti t	le XIX	Hospi tal	Cost	
			·		Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	5551 5511to. 25551 Pt. 511	(from Wkst. B,	Adj.	10101 00010	Di sal I owance	10141 00010	
		Part I, col.	Adj.		Di Sai i Owance		
		26)					
			2.00	2.00	4.00	Г 00	
	INDATI ENT POUTINE CERVI OF COCT CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 947, 921		3, 947, 92		-, ,	
31. 00	03100 INTENSIVE CARE UNIT	1, 143, 378		1, 143, 37	3 0	1, 143, 378	31. 00
41.00	04100 SUBPROVI DER - I RF	0			0	0	41.00
42.00	04200 SUBPROVI DER	0			0	0	42.00
43.00	04300 NURSERY	210, 565		210, 56	5 0	210, 565	43.00
	ANCILLARY SERVICE COST CENTERS				-1		1
50.00	05000 OPERATING ROOM	3, 444, 346		3, 444, 34	5 0	3, 444, 346	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	32, 598		32, 59			
	05400 RADI OLOGY-DI AGNOSTI C						
54.00		4, 142, 006		4, 142, 00		1, 1, 12, 000	
57. 00	05700 CT SCAN	0			0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0	0	59. 00
60.00	06000 LABORATORY	2, 447, 210		2, 447, 210	0	2, 447, 210	60.00
60. 01	06001 BLOOD LABORATORY	0			0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	107, 068		107, 06	3 0	107, 068	63. 00
65. 00	06500 RESPIRATORY THERAPY	1, 653, 622	0				
66. 00	06600 PHYSI CAL THERAPY	1, 110, 533	0	1, 110, 53		1, 110, 533	
66. 01	06601 KV HEALTH PT	1, 110, 333	0			1, 047, 885	
				1, 047, 88			
67. 00	06700 OCCUPATI ONAL THERAPY	750, 068		750, 06		750, 068	
67. 01	06701 KV HEALTH OT	295, 655	0	295, 65		295, 655	
68. 00	06800 SPEECH PATHOLOGY	236, 121	0	236, 12	1 0	236, 121	68. 00
68. 01	06801 KV HEALTH ST	220, 140	0	220, 140	0	220, 140	68. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	305, 999		305, 99	9 0	305, 999	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	56, 986		56, 98			1
	07300 DRUGS CHARGED TO PATIENTS	2, 783, 971		2, 783, 97		,	73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	2,705,771		2, 100, 71	1	2,703,771	73.00
88. 00	08800 RURAL HEALTH CLINIC	384, 713		384, 71	3 0	384, 713	88. 00
	I I						
88. 03	08801 RURAL HEALTH CLINIC IV	504, 236		504, 23		,	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			-	0	89. 00
90.00	09000 CLI NI C	1, 465, 869		1, 465, 869		1, 465, 869	
91. 00	09100 EMERGENCY	2, 990, 191		2, 990, 19	1 0	2, 990, 191	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 023, 349		1, 023, 34	9	1, 023, 349	92.00
93.00	04040 FAMILY PRACTICE	0			0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS					'	1
101 00	10100 HOME HEALTH AGENCY	2, 261, 369		2, 261, 36		2, 261, 369	101 00
101.00	SPECIAL PURPOSE COST CENTERS	2,201,307		2,201,00	´1	2,201,307	1.51.55
116 00	11600 HOSPI CE	542,074		542, 07	1	542, 074	116 00
200.00		33, 107, 873					
201.00		1, 023, 349		1, 023, 34		1, 023, 349	
202.00	Total (see instructions)	32, 084, 524	0	32, 084, 52	4 0	32, 084, 524	202. 00

| Peri od: | Worksheet C | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: |

					0 12/31/2014	12/21/2015 2:	
			Ti t	le XIX	Hospi tal	Cost	07 piii
			Charges		1.00 1.00		
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col . 7)	Ratio	Inpatient	
				,	11	Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•	•		
30.00	03000 ADULTS & PEDI ATRI CS	2, 869, 187		2, 869, 187	7		30.00
31. 00	03100 I NTENSI VE CARE UNI T	651, 475		651, 475			31.00
41.00	04100 SUBPROVI DER - I RF	0					41.00
42.00	04200 SUBPROVI DER	0					42.00
43.00	04300 NURSERY	37, 845		37, 845	5		43.00
	ANCILLARY SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,			'		
50.00	05000 OPERATI NG ROOM	1, 129, 246	3, 150, 445	4, 279, 69	0. 804812	0. 000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	22, 550	15, 910	38, 460	0. 847582	0.000000	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	690, 447	7, 691, 595			0.000000	54.00
57. 00	05700 CT SCAN	0	0	(1	0.000000	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0		0. 000000	0.000000	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		1	0.000000	
60. 00	06000 LABORATORY	1, 499, 342	7, 478, 667	8, 978, 009		0. 000000	1
60. 01	06001 BLOOD LABORATORY	0	0	(0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	145, 800	142, 091	287, 89		0. 000000	
65. 00	06500 RESPI RATORY THERAPY	1, 431, 812	1, 450, 408			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	210, 505	1, 240, 669			0. 000000	1
66. 01	06601 KV HEALTH PT	0	1, 127, 417			0. 000000	1
67.00	06700 OCCUPATI ONAL THERAPY	124, 520	237, 696			0.000000	1
67. 01	06701 KV HEALTH OT	0	167, 687			0.000000	1
68. 00	06800 SPEECH PATHOLOGY	30, 990	103, 514			0.000000	1
68. 01	06801 KV HEALTH ST	0	110, 469			0.000000	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	1		0. 000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	180, 875	627, 910	808, 785		0. 000000	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	40, 415	87, 555			0.000000	1
	07300 DRUGS CHARGED TO PATIENTS	1, 951, 357	4, 416, 150			0. 000000	1
	OUTPATIENT SERVICE COST CENTERS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	.,,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1
88. 00	08800 RURAL HEALTH CLINIC	0	340, 831	340, 83	1. 128750	0. 000000	88. 00
88. 03	08801 RURAL HEALTH CLINIC IV	0	352, 681			0. 000000	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0. 000000	
90.00	09000 CLI NI C	164, 632	2, 249, 808	1		0. 000000	
91. 00	09100 EMERGENCY	85, 144	2, 454, 125			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	256, 166	1, 386, 713			0. 000000	1
93. 00	04040 FAMILY PRACTICE	0	0			0. 000000	1
70.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		1	0. 000000	0.00000	70.00
101 00	10100 HOME HEALTH AGENCY	0	1, 360, 921	1, 360, 92			101. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>	1,000,721	1,7000,72			1.01.00
116.00	11600 HOSPI CE	0	966, 979	966, 979			116. 00
200.00		11, 522, 308	37, 160, 241		1		200.00
201.00		, 322, 300	3., 133, 211	13,332,01			201. 00
202.00		11, 522, 308	37, 160, 241	48, 682, 549			202. 00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	,			1		

Health Financial Systems	JASPER COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151324	Peri od: Worksheet C From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

					12/21/2015 2:	09 pm
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
41. 00	04100 SUBPROVI DER - I RF					41.00
42. 00	04200 SUBPROVI DER					42. 00
43. 00	04300 NURSERY					43. 00
10.00	ANCILLARY SERVICE COST CENTERS	1				10.00
50.00	05000 OPERATING ROOM	0. 000000				50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
57. 00	05700 CT SCAN	0. 000000				57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000				58.00
	1 1					
59. 00	05900 CARDI AC CATHETERI ZATI ON	0.000000				59.00
60.00	06000 LABORATORY	0. 000000				60.00
60. 01	06001 BLOOD LABORATORY	0. 000000				60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000				65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000				66. 00
66. 01	06601 KV HEALTH PT	0. 000000				66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
67. 01	06701 KV HEALTH OT	0. 000000				67. 01
68. 00	06800 SPEECH PATHOLOGY	0. 000000				68. 00
68. 01	06801 KV HEALTH ST	0. 000000				68. 01
		0. 000000				70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. 00
72. 00		0. 000000				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				88. 00
88. 03	08801 RURAL HEALTH CLINIC IV	0. 000000				88. 03
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89. 00
90.00	09000 CLI NI C	0. 000000				90.00
91.00	09100 EMERGENCY	0. 000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
93.00	04040 FAMILY PRACTICE	0. 000000				93. 00
	OTHER REIMBURSABLE COST CENTERS					
101.00	10100 HOME HEALTH AGENCY					101. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>				
116.00	11600 HOSPI CE					116. 00
200.00						200.00
201.00						201.00
202.00						202. 00
202.00	1.014. (300 111311 4011 0113)	1				1-02. 00

Heal th Financial	Systems				JASPER COUNTY HO	SPI TAL		In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF	I NPATI ENT	ANCI LLARY	SERVI CE	CAPI TAL	COSTS	Provi der CCN:	151324	Peri od:	Worksheet D
								From 01/01/2014	

52. 00 05200 DELI VERY ROOM & LABOR ROOM 4,588 38,460 0.119293 0 0 52.0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 221,405 8,382,042 0.026414 468,222 12,368 54. 57. 00 05700 CT SCAN 0 0.000000 0 0.000000 0 57. 58. 00 05800 MAGNETI C RESONANCE I IMAGI NG (MRI) 0 0 0.000000 0 0.000000 0 0.57. 60. 00 06000 LABORATORY 65,637 8,978,009 0.007311 938,092 6,858 60. 60. 60. 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.0000000 0 0.000000 0 0.0	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014		pared:
Related Cost Grom Wisst. C to Charges Cool umn 3 x Cool umn 4 Part II, col. 26) Part II, col. 26) Part II, col. 26) Part II, col. 27) Part II, col. 20) Part III, co							
CFORM WEST, B. Part II, col. Col. 1 + Col. Charges Column 4)	Cost Center Description	Capi tal	Total Charges	Ratio of Cost		Capital Costs	
Part 11, col. 8) 2)							
ANCILLARY SERVICE COST CENTERS					. Charges	column 4)	
1.00 2.00 3.00 4.00 5.00 5.00			8)	2)			
ANCILLARY SERVICE COST CENTERS 50.0 05000 05PRATI ING ROOM 246, 731 4, 279, 691 0.057652 621, 937 35, 856 50.0 6500 05EQ DELIVERY ROOM & LABOR ROOM 4, 588 38, 460 0.119293 0 0.52.0 52.0 05EQ DELIVERY ROOM & LABOR ROOM 4, 588 38, 460 0.119293 0 0.52.0 52.0 05EQ DELIVERY ROOM & LABOR ROOM 4, 588 38, 840 0.119293 0 0 0.200000 0 0.52.0 0.26414 468, 222 12, 368 54.0 0.26414 468, 222 46.0 0.26414 468, 222 46.0 0.26414 46.0							
50.00		1.00	2.00	3. 00	4. 00	5. 00	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		_					
54.00 D\$400 RADI OLOGY-DI AGNOSTI C 221,405 8,382,042 0.026414 468,222 12,368 54.0 57.00 D\$700 CT SCAN 0 0.000000 0 0.57.0 58.00 D\$5900 CARDI AC CATHETERI ZATI ON 0 0.000000 0 0.000000 60.00 D\$6000 CARDI AC CATHETERI ZATI ON 0 0.000000 0.000000 0 0.58.6 60.01 D\$6000 LABORATORY 65,637 8,978.009 0.007311 938.092 6,858 60.0 60.01 0.60001 BLOOD LABORATORY 0 0.000000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00000 0 0.00							
57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 0						1	
58. 00 0 58900 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0.000000 0 0.000000 0 0 59. 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0.000000 0 0 59. 0 60. 01 06000 LABORATORY 0 0 0.000000 0 0 0.00000 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 4, 410 287, 891 0.015318 117, 799 1, 804 63. 0 65. 00 06500 RESPI RATORY THERAPY 75, 709 2, 882, 220 0.026268 1, 145, 008 30, 077 65. 0 66. 01 06600 PHYSI CAL THERAPY 75, 709 2, 882, 220 0.026268 1, 145, 008 30, 077 65. 0 66. 01 06601 KV HEALTH PT 162, 080 1, 127, 417 0.143762 0 0 66. 1 67. 01 06701 KV HEALTH PT 162, 080 1, 127, 417 0.143762 0 0 67. 0 68. 01 06601 KV HEALTH PT 1 162, 080 1, 179, 687 0.276062		221, 405	8, 382, 042			12, 368	
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0.000000 0 0.000000 0 0.000000 0		0	(0.00000	0	0	57. 00
60. 00 06000 LABORATORY 65, 637 8, 978, 009 0. 007311 938, 092 6, 858 60. 0 60. 01 06001 BLOOL LABORATORY 0 0 0. 0000000 0 0 60. 60. 0 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 4, 410 287, 891 0. 015318 117, 799 1, 804 63. 0 65. 00 06500 RESPIRATORY THERAPY 75, 709 2, 882, 220 0. 026268 1, 145, 008 30, 077 65. 0 66. 00 06600 PHYSI CAL THERAPY 57, 038 1, 451, 174 0. 039305 94, 968 3, 733 66. 0 67. 00 06700 0CCUPATI ONAL THERAPY 37, 468 362, 216 0. 103441 55, 050 5, 694 67. 0 68. 01 06601 kV HEALTH DT 46, 292 167, 687 0. 276062 0 0. 66. 0 68. 01 06801 kV HEALTH ST 34, 474 110, 469 0. 312069 0 0 0. 68. 0 68. 01 06801 kV HEALTH ST 34, 474 110, 469 0. 312069 0 0 0. 68. 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0. 0000000 0 0 0. 000000 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 23, 330 808, 785 0. 028846 97, 453 2, 811 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 35, 063 6, 367, 507 0. 005507 781, 842 4, 306 073. 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 35, 063 6, 367, 507 0. 005507 781, 842 4, 306 0. 88. 0 88. 00 08800 RURAL HEALTH CLINIC 1 1, 970 340, 831 0. 005780 0 0 88. 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0. 000000 0 0 0 88. 0 90. 00 90000 CLINIC 1 16, 327 2, 539, 269 0. 045811 7, 690 352 91. 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 99, 960 1, 642, 879 0. 060844 0 0 0 92. 0	58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	(0	58. 00
60. 01	59. 00 05900 CARDI AC CATHETERI ZATI ON	0	(0.00000	0 0	0	59. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 4,410 287,891 0.015318 117,799 1,804 63.00 65.00 06500 RESPIRATORY THERAPY 75,709 2,882,220 0.026268 1,145,008 30,077 65.00 66.00 06600 PHYSI CAL THERAPY 57,038 1,451,174 0.039305 94,968 3,733 66.00 66.01 06601 KV HEALTH PT 162,080 1,127,417 0.143762 0 0 0 66.00 67.00 0600 000		65, 637	8, 978, 009	0. 00731	1 938, 092	6, 858	60.00
65. 00 06500 RESPIRATORY THERAPY 75, 709 2, 882, 220 0. 0.026268 1, 145, 008 30, 077 65. 06. 00 06600 PHYSI CAL THERAPY 57, 038 1, 451, 174 0. 039305 94, 968 3, 733 66. 06. 00 06601 KV HEALTH PT 162, 080 1, 127, 417 0. 143762 0 0 66. 00 06700 0CCUPATI ONAL THERAPY 37, 468 362, 216 0. 103441 55, 050 5, 694 67. 06. 00 06701 KV HEALTH OT 46, 292 167, 687 0. 276062 0 0 0 67. 06. 06. 06. 06. 06. 06. 06. 06. 06. 06	60. 01 06001 BLOOD LABORATORY	0	(0.00000	0	0	60. 01
66. 00 06600 PHYSI CAL THERAPY 57,038 1,451,174 0.039305 94,968 3,733 66.06 66.01 06601 KV HEALTH PT 162,080 1,127,417 0.143762 0 0 66.06 67.00 06700 0680	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	4, 410	287, 891	0. 01531	8 117, 799	1, 804	63.00
66. 01	65. 00 06500 RESPIRATORY THERAPY	75, 709	2, 882, 220	0. 02626	8 1, 145, 008	30, 077	65.00
67. 00 06700 OCCUPATI ONAL THERAPY 37, 468 362, 216 0. 103441 55, 050 5, 694 67. 067. 07. 06701 KV HEALTH OT 46, 292 167, 687 0. 276062 0 0 67. 07. 07. 07. 07. 07. 07. 07. 07. 07. 0	66. 00 06600 PHYSI CAL THERAPY	57, 038	1, 451, 174	0. 03930	5 94, 968	3, 733	66.00
67. 01	66. 01 06601 KV HEALTH PT	162, 080	1, 127, 417	0. 14376	2 0	0	66. 01
68. 00 06800 SPEECH PATHOLOGY 11, 791 134, 504 0. 087663 22, 820 2, 000 68. 068. 01 06801 KV HEALTH ST 34, 474 110, 469 0. 312069 0 0 0 0. 000000 0 0 0. 000000 0	67. 00 06700 OCCUPATI ONAL THERAPY	37, 468	362, 216	0. 10344	1 55, 050	5, 694	67. 00
68. 01 06801 KV HEALTH ST 34, 474 110, 469 0.312069 0 0 68. 070. 00 070. 0	67. 01 06701 KV HEALTH OT	46, 292	167, 687	0. 27606	2 0	0	67. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0	68. 00 06800 SPEECH PATHOLOGY	11, 791	134, 504	0. 08766	3 22, 820	2,000	68. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 23,330 808,785 0.028846 97,453 2,811 71.07 72.00	68. 01 06801 KV HEALTH ST	34, 474	110, 469	0. 31206	9 0	0	68. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 3, 613 127, 970 0. 028233 27, 995 790 72. 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 35, 063 6, 367, 507 0. 005507 781, 842 4, 306 73. 0 000000000000000000000000000000000	70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0. 00000	0 0	0	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 3, 613 127, 970 0.028233 27, 995 790 72. 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 35, 063 6, 367, 507 0.005507 781, 842 4, 306 73. 0 000000000000000000000000000000000	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	23, 330	808, 785	0. 02884	6 97, 453	2, 811	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 35,063 6,367,507 0.005507 781,842 4,306 73.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 613	127, 970	0. 02823	3 27, 995	790	72.00
SECTION SERVICE COST CENTERS SECTION SERVICE COST CENTERS SECTION	73.00 07300 DRUGS CHARGED TO PATIENTS	35, 063	6, 367, 507	0. 00550			73.00
88. 00 08800 RURAL HEALTH CLINIC 1,970 340,831 0.005780 0 0 88. 0 88. 03 88. 03 88. 01 RURAL HEALTH CLINIC I V 53,752 352,681 0.152410 0 0 88. 0 89. 00 89. 00 60,000000 0 0 0 0 0 0 0 0	OUTPATIENT SERVICE COST CENTERS	<u>'</u>					1
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0 0 89. 0 09000 0 0 0 0 0 0 0		1, 970	340, 831	0. 00578	0 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0 0 89. 0 09000 0 0 0 0 0 0 0						0	88. 03
90. 00 09000 CLI NI C 107, 116 2, 414, 440 0. 044365 105, 493 4, 680 90. 0 91. 00 09100 EMERGENCY 116, 327 2, 539, 269 0. 045811 7, 690 352 91. 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 99, 960 1, 642, 879 0. 060844 0 0 92. 0		0	(0	89. 00
91. 00 09100 EMERGENCY 116, 327 2, 539, 269 0. 045811 7, 690 352 91. 0 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 99, 960 1, 642, 879 0. 060844 0 0 92. 0		107, 116	2, 414, 440	•		4, 680	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 99,960 1,642,879 0.060844 0 0 92.0				•			
						i e	1
		0	., (·	1
200.00 Total (Lines 50-199) 1, 408, 754 42, 796, 142 4, 484, 369 111, 329 200.0		1, 408, 754	42, 796, 142	1		111, 329	

Health Financial Systems	JASPER COUN	In Lieu of Form CMS-2552-10				
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PAS	S Provi der	CCN: 151324	From 01/01/2014	Worksheet D Part IV Date/Time Pre 12/21/2015 2:	
		Ti t	le XVIII	Hospi tal	Cost	
Coot Contan Docomintion	Non Dhuci ci on	Nursing Cabasi	Allind Haaltk	All Others	Tatal Cast	

					0 12/31/2014	12/21/2015 2:	
			Ti tl	e XVIII	Hospi tal	Cost	<u>0 7 </u>
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0	0	C	0	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54. 00
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	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00	06000 LABORATORY	0	0	0	0	0	60. 00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	0	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	0	0	0	0	0	67. 00
67. 01	06701 KV HEALTH OT	0	0	0	0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
68. 01	06801 KV HEALTH ST	0	0	0	0	0	68. 01
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
88. 03	08801 RURAL HEALTH CLINIC IV	0	0	0	0	0	88. 03
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLI NI C	0	0	0	0	0	90. 00
91. 00	09100 EMERGENCY	0	0	C	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	C	0	0	
	04040 FAMILY PRACTICE	0	0	C	0	0	
200.00	Total (lines 50-199)	0	0	[C	0	0	200. 00

Health Financial Sy	th Financial Systems JASPER COUNTY HOSPITAL In I							u of Form CMS-2	2552-10
APPORTI ONMENT OF IT	NPATI ENT/OUTPATI ENT	ANCILLARY S	ERVICE OTHER PASS	6	Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 12/21/2015 2:	pared: 09 pm
					Ti tl	e XVIII	Hospi tal	Cost	
Cost C	Center Description		Total			Ratio of Cos	t Outpatient	I npati ent	
			Outpati ent	(fror	n Wkst. C,	to Charges	Ratio of Cost	Program	
			Cost (sum of	Part	t 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	

Total Outpatient Cost (sum of cot 2, 3 and 2					e XVIII	Hospi tal	Cost	
Cost (sum of col 2, 3 and all col 2, 3		Cost Center Description	Total				I npati ent	
ANCI LLARY SERVI CE COST CENTERS			Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
4)			Cost (sum of		(col. 5 ÷ col.		Charges	
ANCI LLARY SERVICE COST CENTERS			col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
ANCI LLARY SERVICE COST CENTERS						. ,		
50. 00 05000 OPERATI NG ROOM 0 4, 279, 691 0.000000 0.000000 621, 937 50. 00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 38, 460 0.000000 0.000000 0.000000 621, 937 55. 00 05400 RADIO LOGY-DI AGNOSTI C 0 8, 382, 042 0.000000 0.000000 0.000000 0.52. 00 0.5700 CT SCAN 0 0 0.000000 0.000000 0.000000 0.57. 00 0.5700 0.5700 CT SCAN 0 0 0.000000 0.000000 0.000000 0.58. 00 0.000000 0.000000 0.000000 0.58. 00 0.000000 0.000000 0.000000 0.59. 00 0.000000 0.000000 0.000000 0.58. 00 0.000000 0.000000 0.000000 0.59. 00 0.000000 0.000000 0.000000 0.59. 00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00			6.00	7. 00	8. 00	9. 00	10.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 38, 460 0.000000 0.000000 0.000000 52.00								
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 8,382,042 0.000000 0.000000 468,222 54. 00 57. 00 05700 CT SCAN 0 0.000000 0.000000 0.570.0 58. 00 05800 MASKETI C RESONANCE I MAGI NG (MRI) 0 0.000000 0.000000 0.590.0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0.000000 0.000000 0.590.0 60. 01 06001 BLOOD LABORATORY 0 0.000000 1.17,799 63.00 0.000000 0.000000 1.145,008 65.00 66.00 RESPI RATORY THERAPY 0 1.451,174 0.000000 0.000000 1.145,008 66.00 66.00 RESPI RATORY THERAPY 0 <	50.00	05000 OPERATING ROOM	0	4, 279, 691	0.000000	0.000000	621, 937	50.00
57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 0	52.00	05200 DELIVERY ROOM & LABOR ROOM	0	38, 460	0.000000	0.000000	0	52. 00
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0.000000 0.000000 0.000000 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0.000000 0.000000 0.000000 0.5900 0.000000 1.17,799 63. 00 0.00000 0.000000 0.000000 1.145,008 65. 00 0.00000 0.000000 0.000000 1.145,008 65. 00 0.00000 0.000000 0.000000 1.145,008 65. 00 0.00000 0.000000 0.000000 1.145,008 65. 00 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	54.00	05400 RADI OLOGY-DI AGNOSTI C	0	8, 382, 042	0.000000	0.000000	468, 222	54. 00
59.00 05900 CARDIAC CATHETERIZATION 0 0 0.000000 0.000000 0.000000 938,092 60.00 60.01 06000 LABORATORY 0 8,978,009 0.000000 0.000000 938,092 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 287,891 0.000000 0.000000 117,799 63.00 65.00 06500 RESPI RATORY THERAPY 0 2,882,220 0.000000 0.000000 1,145,008 65.00 66.00 06600 PHYSI CAL THERAPY 0 1,451,174 0.000000 0.000000 94,968 66.00 66.01 06601 KV HEALTH PT 0 1,127,417 0.000000 0.000000 55,050 67.00 67.01 06701 KV HEALTH OT 0 167,687 0.000000 0.000000 55,050 67.01 68.01 06800 SPECH PATHOLOGY 0 134,504 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000	57.00	05700 CT SCAN	0	0	0.000000	0.000000	0	57. 00
60. 00	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58. 00
60. 01	59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0.000000	0.000000	0	59. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 287, 891 0.000000 0.000000 117, 799 63. 00 65. 00 06500 RESPIRATORY THERAPY 0 2, 882, 220 0.000000 0.000000 1, 145, 008 65. 00 06600 PHYSI CAL THERAPY 0 1, 451, 174 0.000000 0.000000 94, 968 66. 00 06601 KV HEALTH PT 0 1, 127, 417 0.000000 0.000000 0.000000 0.66. 01 0670 0CCUPATI ONAL THERAPY 0 362, 216 0.000000	60.00	06000 LABORATORY	0	8, 978, 009	0.000000	0.000000	938, 092	60.00
65. 00	60. 01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60. 01
66. 00 06600 PHYSI CAL THERAPY 0 1, 451, 174 0.000000 0.000000 94, 968 66. 00 66. 01 06601 KV HEALTH PT 0 1, 127, 417 0.000000 0.000000 0 66. 01 67. 00 06700 OCCUPATI ONAL THERAPY 0 362, 216 0.000000 0.000000 55, 050 67. 00 67. 01 06701 KV HEALTH OT 0 167, 687 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	287, 891	0.000000	0.000000	117, 799	63.00
66. 01 06601 KV HEALTH PT 0 1,7417 0.000000 0.000000 0 66. 01 67. 00 06700 0CCUPATI ONAL THERAPY 0 362, 216 0.000000 0.000000 55, 050 67. 00 67. 01 06701 KV HEALTH OT 0 167, 687 0.000000 0.000000 0.000000 0 67. 01 68. 00 06800 SPEECH PATHOLOGY 0 134, 504 0.000000 0.000000 0.000000 0.000000 0.000000	65.00	06500 RESPI RATORY THERAPY	0	2, 882, 220	0. 000000	0.000000	1, 145, 008	65.00
67. 00 06700 0CCUPATI ONAL THERAPY 0 362, 216 0.000000 0.000000 55, 050 67. 00 67. 01 06701 KV HEALTH OT 0 167, 687 0.000000 0.000000 0.000000 0.7000000 68. 00 06800 SPEECH PATHOLOGY 0 134, 504 0.000000 0.000000 22, 820 68. 00 68. 01 06801 KV HEALTH ST 0 110, 469 0.000000 0.000000 0.000000 0.000000 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0.000000 0.000000 0.000000 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 808, 785 0.000000 0.000000 0.000000 97, 453 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 63, 367, 507 0.000000 0.000000 781, 842 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 63, 367, 507 0.000000 0.000000 781, 842 88. 00 08800 RURAL HEALTH CLINIC V 0 352, 681 0.000000 0.000000 0.000000 0.88. 03 89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 91. 00 09100 EMERGENCY 0 2, 539, 269 0.000000 0.000000 7, 690 91. 00 10 167, 687 0.0000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.000000	66.00	06600 PHYSI CAL THERAPY	0	1, 451, 174	0.000000	0.000000	94, 968	66. 00
67. 01 06701 KV HEALTH OT 0 167, 687 0.000000 0.000000 0 67. 01 68. 00 06800 SPEECH PATHOLOGY 0 134, 504 0.000000 0.000000 22, 820 68. 00 68. 01 06801 KV HEALTH ST 0 110, 469 0.000000 0.000000 0 68. 01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0.000000 0.000000 0 70. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 808, 785 0.000000 0.000000 97, 453 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 127, 970 0.000000 0.000000 27, 995 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 6, 367, 507 0.000000 0.000000 781, 842 73. 00 000000 0.000000 0.000000 0.000000 0.000000	66. 01	06601 KV HEALTH PT	0	1, 127, 417	0.000000	0.000000	0	66. 01
68. 00 06800 SPEECH PATHOLOGY 0 134, 504 0.000000 0.000000 22, 820 68. 00 68. 01 06801 KV HEALTH ST 0 110, 469 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000	67.00	06700 OCCUPATI ONAL THERAPY	0	362, 216	0.000000	0.000000	55, 050	67. 00
68. 01 06801 KV HEALTH ST 0 110, 469 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	67. 01	06701 KV HEALTH OT	0	167, 687	0. 000000	0. 000000	0	67. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0.000000 0 70.00 71.00	68. 00	06800 SPEECH PATHOLOGY	0	134, 504	0. 000000	0. 000000	22, 820	68. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 808, 785 0.000000 0.000000 97, 453 71. 00 72. 00 72. 00 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 6, 367, 507 0.000000 0.000000 781, 842 73. 00	68. 01	06801 KV HEALTH ST	0	110, 469	0. 000000	0. 000000	0	68. 01
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 127, 970 0.000000 0.000000 27, 995 72. 00 07300 DRUGS CHARGED TO PATIENTS 0 6, 367, 507 0.000000 0.000000 781, 842 73. 00 000000 0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000	70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0. 000000	0. 000000	0	70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 6, 367, 507 0.000000 0.000000 781, 842 73. 00 000000 0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	808, 785	0. 000000	0. 000000	97, 453	71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 6, 367, 507 0.000000 0.000000 781, 842 73. 00 0UTPATIENT SERVICE COST CENTERS 88. 00 08801 RURAL HEALTH CLINIC 0 340, 831 0.000000 0.000000 0 88. 03 88. 03 08801 RURAL HEALTH CLINIC IV 0 352, 681 0.000000 0.000000 0 88. 03 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0.000000 0.000000 0 88. 03 90. 00 09000 CLINIC 0 2, 414, 440 0.000000 0.000000 105, 493 90. 00 91. 00 09100 EMERGENCY 0 2, 539, 269 0.000000 0.000000 7, 690 91. 00	72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	127, 970	0. 000000	0. 000000	27, 995	72. 00
88. 00 08800 RURAL HEALTH CLINIC 0 340, 831 0.000000 0.000000 0 88. 00 88. 03 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.0000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 367, 507			781, 842	73. 00
88. 03 08801 RURAL HEALTH CLINIC IV 0 352, 681 0.000000 0.000000 0 88. 03 89. 00 89. 00 600000 6000000 6000000 6000000 6000000 60000000 60000000 600000000		OUTPATIENT SERVICE COST CENTERS				'		
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	88. 00	08800 RURAL HEALTH CLINIC	0	340, 831	0.000000	0.000000	0	88. 00
90. 00 09000 CLI NI C 0 2, 414, 440 0. 000000 0. 000000 105, 493 90. 00 91. 00 91. 00 2, 539, 269 0. 000000 0. 000000 7, 690 91. 00	88. 03	08801 RURAL HEALTH CLINIC IV	0	352, 681	0. 000000	0. 000000	0	88. 03
91. 00 09100 EMERGENCY 0 2, 539, 269 0. 000000 0. 000000 7, 690 91. 00	89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 000000	0. 000000	0	89. 00
91. 00 09100 EMERGENCY 0 2, 539, 269 0. 000000 0. 000000 7, 690 91. 00	90.00	09000 CLI NI C	0	2, 414, 440	0. 000000	0. 000000	105, 493	90.00
		09100 EMERGENCY	0		•		•	91.00
			0		•		0	1
93. 00 04040 FAMILY PRACTICE 0 0.000000 0.000000 0 93. 00			0	0	•		0	
200.00 Total (lines 50-199) 0 42,796,142 4,484,369 200.00		Total (lines 50-199)	0	42, 796, 142	•		4, 484, 369	1

Health Financial Systems

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

JASPER COUNTY HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 151324
From 01/01/2014
To 12/31/2014
Date/Time Prepared:

				To 12/31/201	14 Date/Time Pr 12/21/2015 2	
		Ti t	le XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9	7		
	x col. 10)		x col. 12)			
	11.00	12. 00	13. 00			
ANCILLARY SERVICE COST CENTERS			٠,	al		4
50. 00 05000 OPERATI NG ROOM	0	(0	0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	(0	0		52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	(0	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	0	(0		60.00
60. 01 06001 BLOOD LABORATORY	0	(0		60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 65. 00 06500 RESPIRATORY THERAPY	0	(0		63. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0	(0		66.00
66. 01 06601 KV HEALTH PT	0	(0		66. 01
67. 00 06700 OCCUPATI ONAL THERAPY	0	(0		67. 00
67. 01 06700 00000ATT ONAL THERAPT	0	(0		67. 01
68. 00 06800 SPEECH PATHOLOGY	0	(0		68. 00
68. 01 06801 KV HEALTH ST	0	,		0		68. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	·		0		71.00
72. 00 07700 IMPL. DEV. CHARGED TO PATIENT		·		0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		- I	0		73.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	<u> </u>		70.00
88. 00 08800 RURAL HEALTH CLINIC	0	(ol	0		88. 00
88. 03 08801 RURAL HEALTH CLINIC IV	0	(o	0		88. 03
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	(o	0		89. 00
90. 00 09000 CLI NI C	0	(0	0		90.00
91. 00 09100 EMERGENCY	0	(o	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	(0	0		92. 00
93.00 04040 FAMILY PRACTICE	0	(0	0		93. 00
200.00 Total (lines 50-199)	o	(0	o		200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 151324 Peri od: Worksheet D From 01/01/2014 Part V 12/31/2014 Date/Time Prepared: 12/21/2015 2:09 pm Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.804812 1, 315, 185 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.847582 120 0 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 2, 676, 573 54 00 0 494152 0 54 00 0 57.00 05700 CT SCAN 0.000000 0 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 0 0 0 0 0 0 0 0 0 59.00 0 0 06000 LABORATORY 0 60.00 0.272578 3, 167, 045 0 60.00 60.01 06001 BLOOD LABORATORY 0.000000 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0. 371905 111,023 0 63.00 06500 RESPIRATORY THERAPY 627, 127 65 00 0.573732 0 65 00 06600 PHYSI CAL THERAPY 66.00 0.765265 376, 586 0 66.00 66.01 06601 KV HEALTH PT 0. 929456 228, 311 0 66.01 67.00 06700 OCCUPATIONAL THERAPY 2.070775 35, 793 67.00 0 67.01 06701 KV HEALTH OT 11, 647 1.763136 0 0 67.01 68.00 06800 SPEECH PATHOLOGY 1. 755494 0 21,660 0 68.00 06801 KV HEALTH ST 1. 992776 12, 975 68.01 68.01 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 116, 292 71.00 71.00 0.378344 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.445307 31, 626 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 2, 071, 290 73.00 73.00 0.437215 388 0 OUTPATIENT SERVICE COST CENTERS 88 00 88 00 08800 RURAL HEALTH CLINIC 0.000000 0 88.03 08801 RURAL HEALTH CLINIC IV 0.000000 0 88.03 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0.000000 89.00 09000 CLINIC 0.607126 90.00 90.00 1, 035, 365 493 0 91.00 09100 EMERGENCY 1. 177579 0 713, 097 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.622900 0 92.00 736, 372 0 93.00 04040 FAMILY PRACTICE 0.000000 0 0 0 93.00 200.00 Subtotal (see instructions) C 200.00 13, 288, 087 881 0 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges

13, 288, 087

881

0 202. 00

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems	JASPER COUNTY HOS	SPI TAL	In Lie	ı of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 151324	Peri od:	Worksheet D

From 01/01/2014 Part V To 12/31/2014 Date/Time Prepared: 12/21/2015 2:09 pm Titl<u>e XVIII</u> Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 058, 477 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 102 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 1, 322, 634 0 54 00 54 00 0 57.00 05700 CT SCAN 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 0 60.00 863, 267 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 41, 290 63.00 06500 RESPIRATORY THERAPY 359, 803 65 00 65 00 06600 PHYSI CAL THERAPY 66.00 288, 188 0 66.00 66. 01 06601 KV HEALTH PT 212, 205 66.01 67.00 06700 OCCUPATIONAL THERAPY 74, 119 67.00 0 67.01 06701 KV HEALTH OT 20.535 67.01 68.00 06800 SPEECH PATHOLOGY 38,024 0 68.00 06801 KV HEALTH ST 25, 856 68.01 68.01 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 43, 998 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 14,083 0 72.00 07300 DRUGS CHARGED TO PATIENTS 905, 599 170 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88 00 88 00 08800 RURAL HEALTH CLINIC 0 0 88. 03 08801 RURAL HEALTH CLINIC IV 0 0 88.03 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 09000 CLI NI C 628, 597 299 90.00 90.00 91.00 09100 EMERGENCY 839, 728 C 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 458, 686 92.00 0 93.00 04040 FAMILY PRACTICE 0 93.00 200.00 Subtotal (see instructions) 200. 00 7, 195, 191 469 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

7, 195, 191

469

202.00

202.00

Net Charges (line 200 +/- line 201)

			Component	CCN: 15Z324	To 12/31/2014	Date/Time Pre 12/21/2015 2:	
			Ti tl	e XVIII	Swing Beds - SNF		07 piii
				Charges	oning bodo oni	Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	, and the second		Services (see	Rei mbursed	Rei mbursed	(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	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 804812	0		0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 847582	0		0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 494152	0		0	0	54. 00
57.00	05700 CT SCAN	0. 000000	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59. 00
60.00	06000 LABORATORY	0. 272578	0		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 371905	0		0 0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0. 573732	0		0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 765265	0		0	0	66. 00
66. 01	06601 KV HEALTH PT	0. 929456	0		0 0	0	66. 01
67. 00	06700 OCCUPATI ONAL THERAPY	2. 070775	0		0	0	67. 00
67. 01	06701 KV HEALTH OT	1. 763136	0		0 0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	1. 755494	0		0	0	68. 00
68. 01	06801 KV HEALTH ST	1. 992776	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. 378344	0		0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 445307	0		0 0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 437215	0		0 0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				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 CLI NI C	0. 607126	0		0	0	90.00
91. 00	09100 EMERGENCY	1. 177579	0		0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 622900	0		0	0	
93. 00	04040 FAMILY PRACTICE	0. 000000	0		0	0	
200.00			0		0	0	200. 00
201.00					0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0	1	0 0	0	202. 00

Health Financial Systems

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Component CCN: 151324

Component CCN: 157324

In Lieu of Form CMS-2552-10

Provider CCN: 151324

From 01/01/2014

Part V

Date/Time Prepared:

			Comp	onent	CCN: 15Z324	To 12/31/2014	Date/Time Pr 12/21/2015 2	epared: : 09 pm
				Ti tl ∈	e XVIII	Swing Beds - SNF	Cost	<u> </u>
		Cos	sts					
	Cost Center Description	Cost	Cost					
		Rei mbursed	Rei mburs	sed				
		Servi ces	Servi ces					
		Subject To	Subj ect	To				
		Ded. & Coins.	Ded. & Co					
		(see inst.)	(see ins	t.)				
		6. 00	7.00					
	ANCILLARY SERVICE COST CENTERS							
	05000 OPERATING ROOM	0)	0				50. 00
	05200 DELIVERY ROOM & LABOR ROOM	0)	0				52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0)	0				54. 00
	05700 CT SCAN	0)	0				57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0)	0				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0				59. 00
60.00	06000 LABORATORY	0)	0				60. 00
60. 01	06001 BLOOD LABORATORY	0)	0				60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0)	0				63. 00
65.00	06500 RESPI RATORY THERAPY	0		0				65. 00
66.00	06600 PHYSI CAL THERAPY	0		0				66. 00
66. 01	06601 KV HEALTH PT	0		0				66. 01
67.00	06700 OCCUPATI ONAL THERAPY	0		0				67. 00
67. 01	06701 KV HEALTH OT	0		0				67. 01
68. 00	06800 SPEECH PATHOLOGY	0		0				68. 00
68. 01	06801 KV HEALTH ST	0		0				68. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0				70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	o	o				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		0				73. 00
	OUTPATIENT SERVICE COST CENTERS							
88. 00	08800 RURAL HEALTH CLINIC	0		0				88. 00
88. 03	08801 RURAL HEALTH CLINIC IV	0		0				88. 03
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0				89. 00
90.00	09000 CLI NI C	0		0				90. 00
91.00	09100 EMERGENCY	0		o				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		o				92. 00
93.00	04040 FAMILY PRACTICE	0		o				93. 00
200.00	Subtotal (see instructions)	0		o				200. 00
201.00	Less PBP Clinic Lab. Services-Program	0						201. 00
	Only Charges							
202.00		0)	o				202. 00

Health Financial Systems	JASPER COUNTY HOS	PI TAL		In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der (CCN: 151324	Peri od: From 01/01/2014	Worksheet D-1
				To 12/31/2014	Date/Time Prepared: 12/21/2015 2:09 pm
		Title	e XVIII	Hospi tal	Cost

			12, 01, 2011	12/21/2015 2:	09 pm
		Title XVIII	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		5, 647	1.00
2.00	Inpatient days (including private room days, excluding swing-be			4, 558	2. 00
3.00	Private room days (excluding swing-bed and observation bed days		ivate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation bed	3, 112	4. 00		
5.00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	1, 006	5. 00
	reporting period		04 6 11		, ,,
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	83	7. 00
7.00	reporting period	days) through becomber	or or the cost		7.00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 136	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	1, 006	10. 00
11. 00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII onl		oom dove) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, ent		dolli days) arter		11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	О	12. 00
	through December 31 of the cost reporting period	y (aag p			
13.00	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 yea				
14. 00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost		17. 00
17.00	reporting period	thi dagii becember 31 0	T the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services		18. 00		
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	123. 32	19. 00
20.00	reporting period	-£t Db 21 -£ t		0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	arter becember 31 or t	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)			3, 947, 921	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	22. 00
	5 x line 17)	•			
23.00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (line	10, 236	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or the cost reporting	perrod (rriie o		20.00
26.00	Total swing-bed cost (see instructions)			722, 192	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (ine 21 minus line 26)		3, 225, 729	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)			0	1
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	lino 20)		0. 000000	30. 00 31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	111le 20)		0.00000	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00			
34. 00	Average per diem private room charge differential (line 32 minu	0.00			
35. 00	Average per diem private room cost differential (line 34 x line	0.00	35. 00		
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00		
37. 00	, , ,				
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	TMENTO			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS		ı	707 71	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3	•		707. 71 1, 511, 669	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Program	•		1, 311, 009	40.00
	Total Program general inpatient routine service cost (line 39 +			1, 511, 669	1
		•	'		

	Financial Systems	JASPER COUNT			0011		eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi	der	CCN: 151324	Peri od: From 01/01/2014	Worksheet D-1	
						To 12/31/2014	Date/Time Pre 12/21/2015 2:	
				Title	e XVIII	Hospi tal	Cost	07 piii
	Cost Center Description	Total	Total	D	Average Per			
		Inpatient Cost	inpatient	Days	col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00		3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0	0. (00 (0	42. 00
43. 00	INTENSIVE CARE UNIT	1, 143, 378		510	2, 241.	92 360	807, 091	43. 00
44.00	CORONARY CARE UNIT	,			•			44. 00
45.00	BURN INTENSIVE CARE UNIT							45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)							46. 00 47. 00
171.00	Cost Center Description							171.00
40.00	December 1 and 1 a	-+ D 21 2	11: 200	,			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines				ns)		2, 379, 362 4, 698, 122	1
171.00	PASS THROUGH COST ADJUSTMENTS	c oug.: 10) (0110			1,070,122]
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sur	n of Parts I and	0	50.00
51. 00		atient ancillar	v services	(fr	om Wkst. D. s	sum of Parts II	0	51.00
	and IV)		<i>y</i>	`	,			
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		lated nam	n la v	oioion oncoth	notict and	0	
53.00	medical education costs (line 49 minus line !		nateu, non	-pny:	sician anesti	ietist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	,						1
	Program discharges Target amount per discharge						0.00	
56. 00	Target amount (line 54 x line 55)						0.00	1
57. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amoun	t (I	ine 56 minus	line 53)	0	57. 00
58. 00	Bonus payment (see instructions)	nonting norical	anding 100	,	ndoted and o	ampaundad by +ba	0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	enaring 199	o, u	puateu anu co	inpounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year						0.00	1
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that						0	61.00
	amount (line 56), otherwise enter zero (see		S (TITIES 3	4 X (60), 01 1% 01	the target		
	Relief payment (see instructions)						0	
63. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)				0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of	the	cost reporti	ng period (See	711, 956	64. 00
.	instructions)(title XVIII only)		04 6 1					/ - 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts arter Decemb	er 31 or t	ne c	ost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus li	ne 6	5)(title XVII	I only). For	711, 956	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	o costs through	Docombon	21 0	f the cost re	porting ported	0	67. 00
67.00	(line 12 x line 19)	e costs till ough	December	31 0	i the cost is	sporting perrou		07.00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31	of	the cost repo	orting period	0	68. 00
69 00	(line 13 x line 20) Total title V or XLX swing-bed NF inpatient	routine costs (line 67 ±	line	68)		0	69.00
37.00	PART III - SKILLED NURSING FACILITY, OTHER NU] " " " "
70.00	Skilled nursing facility/other nursing facil	-						70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /0 ÷ I	ine .	2)			71.00
73. 00	Medically necessary private room cost applications		(line 14	x li	ne 35)			73. 00
74.00	Total Program general inpatient routine serv							74.00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	costs (fr	OM W	orksheet B, F	Part II, column		75. 00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)						76. 00
77. 00	Program capital -related costs (line 9 x line	,						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for excess		rovi den ire	cord	s)			78. 00 79. 00
	Total Program routine service costs for compa					nus line 79)		80.00
81.00	Inpatient routine service cost per diem limit		`					81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .					82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		- /					84. 00
85.00	Utilization review - physician compensation							85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)					86. 00
87. 00	Total observation bed days (see instructions						1, 446	87. 00
88. 00	Adjusted general inpatient routine cost per	•	line 2)				707. 71	
84. UU	Observation bed cost (line 87 x line 88) (see	e instructions)					1, 023, 349	84.00

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 12/21/2015 2:0	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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 O	COST					
90.00 Capital -related cost	315, 085	3, 225, 729	0. 09767	9 1, 023, 349	99, 960	90.00
91.00 Nursing School cost	0	3, 225, 729	0.00000	1, 023, 349	0	91.00
92.00 Allied health cost	0	3, 225, 729	0.00000	1, 023, 349	0	92.00
93.00 All other Medical Education	0	3, 225, 729	0. 00000	1, 023, 349	0	93. 00

Health Financial Systems	JASPER COUNTY HOSPITAL	In Li€	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN:	From 01/01/2014	Worksheet D-1 Date/Time Pre 12/21/2015 2:	
	Ti tle XI	X Hospi tal	Cost	
Cost Center Description				

Description
PART ALL PROVIDER COMPORENTS
INPARLIENT DAYS 1.00 Inpatient days (Including private room days, excluding swing-bed and newborn days) 1.00 Inpatient days (Including private room days, excluding swing-bed and newborn days) 1.00 1
Impattent days (including private room days, excluding swing-bed and newborn days) 4,558 2.00
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 0 3.00
do not complete this line. 1. 00 Semi-private room days (excluding swing-bed and observation bed days) 1. 1. 00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1. 00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1. 00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 1. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 1. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 1. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 1. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 1. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 1. 00 Swing-bed SNF type inpatient days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 1. 00 Swing-bed SNF type inpatient days applicable to services through December 31 of the cost reporting period (including private room days) 1. 00 Swing-bed SNF type services applicable to services after December 31 of the cost reporting period (including private room days) 1. 00 Swing-Bed SNF type services applicable to services after Dece
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20.00 Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average perivate room per diem charge (line 29 + line 3) 30.00 Average perivate room per diem charge (line 30 + line 4) 30.00 Average per diem private room cost differential (line 34 x line 31) 20.00 Private room cost differential adjustment (line 34 x line 31) 20.00 Private room cost differential adjustment (line 34 x line 31) 20.00 Private room cost differential adjustment (line 3 x x line 35) 30.00 Private room cost differential adjustment (line 3 x x line 35)
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21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 29 + line 3) 34.00 Average per diem private room charge differential (line 34 x line 31) Private room cost differential adjustment (line 34 x line 31) Private room cost differential adjustment (line 34 x line 31) Private room cost differential adjustment (line 34 x line 35) O 36.00
5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 0 23.00 24.00 25.00 27.00 General inpatient routine service cost net of swing-bed and observation bed charges) 0 28.00 28.00 29.00 30.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0 0.00 32.00 30.00 Average per diem private room charge differential (line 30 ÷ line 4) 0 0.00 33.00 30.00 Average per diem private room cost differential (line 34 x line 31) 0 0.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35)
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 34.00 Average semi-private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 29.00 Average per diem private room cost differential (line 34 x line 35)
x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 10, 236 24.00 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 722, 192 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3, 225, 729 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 0.0000000 31.00 32.00 Average private room per diem charge (line 29 ÷ line 3) 0.00 32.00 Average semi-private room charge differential (line 30 ± line 4) 0.00 33.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 0.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 35.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 36.00 Private room cost differential adjustment (line 3 x line 35) 25.00 Average per diem private room cost differential (line 34 x line 31) 37.00 Average per diem private room cost differential (line 3 x line 35)
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 4.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35)
x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 4.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35)
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 Private room charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Private room cost differential adjustment (line 3 x line 35)
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35)
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35)
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35)
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 0.000000 31.00 0.000000 31.00 0.000000 31.00 0.000000 32.00 0.000000 31.00 0.000000 31.00 0.000000 31.00 0.000000 32.00 0.000000 31.00 0.000000 31.00 0.000000 31.00 0.000000 32.00 0.000000 31.00 0.000000 31.00 0.000000 31.00 0.000000 32.00 0.000000 31.00 0.000000 31.00 0.000000 31.00 0.000000 32.00 0.000000 31.00 0.0000000 31.00
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00 32.00 33.00 0.00 32.00 0.00 33.00 0.00 35.00 0.00 36.00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00 33.00 34.00 35.00 36.00
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00 34.00 35.00 36.00
36.00 Private room cost differential adjustment (line 3 x line 35)
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3,225,729 37.00
27 minus Line 36)
PART II - HOSPITAL AND SUBPROVIDERS ONLY
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 707.71 38.00 709.71 38.00 709.71 38.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 159,235 41.00

Heal th	h Financial Systems JASPER COUNTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
			Period: From 01/01/2014	Worksheet D-1	
			To 12/31/2014	Date/Time Pre	
	Ti 1	tle XIX	Hospi tal	12/21/2015 2: Cost	09 pm
	Cost Center Description Total Total	Average Per	Program Days	Program Cost	
	Inpati ent Cost Inpati ent Days	col. 2)	÷	(col. 3 x col. 4)	
	1.00 2.00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only) 210, 565 66 Intensive Care Type Inpatient Hospital Units	6 3, 190. 3	8 0	0	42. 00
43.00	INTENSIVE CARE UNIT 1, 143, 378 510	0 2, 241. 9	2 0	0	
44. 00 45. 00					44. 00 45. 00
46. 00					46. 00
47. 00	O OTHER SPECIAL CARE (SPECIFY) Cost Center Description				47. 00
	Cost Center Description			1. 00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) Total Program inpatient costs (sum of lines 41 through 48)(see instruction	ons)		324, 046	•
49.00	PASS THROUGH COST ADJUSTMENTS	urs)		483, 281	49.00
50. 00		m Wkst. D, sum	of Parts I and	0	50. 00
51. 00) Pass through costs applicable to Program inpatient ancillary services (fi	rom Wkst. D, s	um of Parts II	0	51. 00
F0 00	and IV)				F0 00
52. 00 53. 00	,	vsician anesth	etist, and	0	52. 00 53. 00
	medical education costs (line 49 minus line 52)				
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges			0	54. 00
55. 00	Target amount per discharge			0. 00	55. 00
56. 00 57. 00	,	line 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)		ŕ	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, unarket basket	updated and co	mpounded by the	0. 00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the r			0. 00	60.00
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the less which operating costs (line 53) are less than expected costs (lines 54 x			0	61. 00
	amount (line 56), otherwise enter zero (see instructions)	00), 01 1% 01	the target		
62. 00 63. 00				0	62. 00 63. 00
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST			0	03.00
64. 00	Medicare swing-bed SNF inpatient routine costs through December 31 of the instructions) (title XVIII only)	e cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the o	cost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 6	65)(title XVII	l only). For	0	66. 00
(7.00	CAH (see instructions)	-6 +1+			/7.00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 ((line 12 x line 19)	or the cost re	borting perrod	U	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of (line 13 x line 20)	the cost repo	rting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line			0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID Skilled nursing facility/other nursing facility/ICF/IID routine service of				70. 00
71. 00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line	, ,			71. 00
72. 00 73. 00	,	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine service costs (line 72 + line 73))			74. 00
75. 00	Capital-related cost allocated to inpatient routine service costs (from V 26, line 45)	Worksheet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line 2)				76. 00
77. 00 78. 00	, ,				77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider record	· .			79. 00
80. 00 81. 00		n (line 78 min	us line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (line 9 x line 81)				82. 00
83. 00 84. 00					83. 00 84. 00
85. 00					85.00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions)			1, 446	87. 00
88. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			707. 71	88. 00
υ 9 . UU	Observation bed cost (line 87 x line 88) (see instructions)			1, 023, 349	U7. UU

Health Financial Systems	JASPER COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Prep 12/21/2015 2:0	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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	315, 085	3, 225, 729	0. 09767	9 1, 023, 349	99, 960	90.00
91.00 Nursing School cost	0	3, 225, 729	0.00000	1, 023, 349	0	91.00
92.00 Allied health cost	0	3, 225, 729	0.00000	1, 023, 349	0	92.00
93.00 All other Medical Education	0	3, 225, 729	0. 000000	1, 023, 349	0	93. 00

Health Financial Systems	JASPER COUNTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151324	Peri od:	Worksheet D-3	
			From 01/01/2014		
			To 12/31/2014	Date/Time Pre	pared:
				12/21/2015 2:	09 pm
	Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cost	Inpati ent	I npati ent	
·		To Charges	Program	Program Costs	
				(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
20 00 02000 ADULTS & DEDLATRICS			1 507 4/2		1 20 00

	Cost Center Description	Ratio of Cost	I npati ent	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			1	
	03000 ADULTS & PEDI ATRI CS		1, 587, 462		30. 00
	03100 I NTENSI VE CARE UNI T		468, 150		31. 00
	04100 SUBPROVI DER - I RF		0		41. 00
	04200 SUBPROVI DER		0		42. 00
43.00	04300 NURSERY				43. 00
	ANCI LLARY SERVI CE COST CENTERS	,			
	05000 OPERATING ROOM	0. 804812	621, 937	500, 542	50. 00
	05200 DELIVERY ROOM & LABOR ROOM	0. 847582	0	0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0. 494152	468, 222	231, 373	54.00
	05700 CT SCAN	0.000000	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0.000000	0	0	59. 00
60.00	06000 LABORATORY	0. 272578	938, 092	255, 703	60.00
60. 01	06001 BLOOD LABORATORY	0.000000	0	0	60. 01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 371905	117, 799	43, 810	63.00
65.00	06500 RESPI RATORY THERAPY	0. 573732	1, 145, 008	656, 928	65.00
66.00	06600 PHYSI CAL THERAPY	0. 765265	94, 968	72, 676	66. 00
66. 01	06601 KV HEALTH PT	0. 929456	0	0	66. 01
67.00	06700 OCCUPATI ONAL THERAPY	2. 070775	55, 050	113, 996	67. 00
67. 01	06701 KV HEALTH OT	1. 763136	0	0	67. 01
68. 00	06800 SPEECH PATHOLOGY	1. 755494	22, 820	40, 060	68. 00
68. 01	06801 KV HEALTH ST	1. 992776	0	0	68. 01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 378344	97, 453	36, 871	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 445307	27, 995	12, 466	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 437215	781, 842	341, 833	73. 00
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0.000000		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
	09000 CLI NI C	0. 607126	105, 493	64, 048	90.00
91.00	09100 EMERGENCY	1. 177579	7, 690		•
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 622900	0	0	92.00
	04040 FAMILY PRACTICE	0.000000	0	0	93.00
200.00			4, 484, 369	2, 379, 362	
201.00			0		201. 00
202.00			4, 484, 369		202. 00
				'	

Health Financial Systems	JASPER COUNTY HOSPITAL	In Lieu	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 151324	Peri od: From 01/01/2014	Worksheet D-3
	Component CCN: 15Z324	To 12/31/2014	Date/Time Prepared:

I NPATI EN	T ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 1	151324	Peri od:	Worksheet D-3	
		Component	+ CCN:	157224	From 01/01/2014 To 12/31/2014	Date/Time Pre	narod:
		Component	L CCN.	132324	10 12/31/2014	12/21/2015 2:	
		Ti tl	e XVI		Swing Beds - SNF		<u> </u>
	Cost Center Description			of Cos		Inpati ent	
				Charges	•	Program Costs	
				3	Charges	(col. 1 x col.	
					ŭ	2)	
				1. 00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDI ATRI CS				0		30. 00
	3100 INTENSIVE CARE UNIT				0		31. 00
	4100 SUBPROVI DER – I RF				0		41. 00
1	4200 SUBPROVI DER				0		42. 00
	4300 NURSERY						43. 00
	NCI LLARY SERVI CE COST CENTERS					,	
	OPERATING ROOM			0.8048		4, 260	1
	5200 DELIVERY ROOM & LABOR ROOM			0.8475		0	52. 00
	5400 RADI OLOGY-DI AGNOSTI C			0. 4941		14, 448	
	5700 CT SCAN			0.0000		0	57. 00
	5800 MAGNETIC RESONANCE IMAGING (MRI)			0.0000		0	58. 00
	5900 CARDI AC CATHETERI ZATI ON			0.0000		0	59. 00
1	6000 LABORATORY			0. 2725		27, 157	60.00
	6001 BLOOD LABORATORY			0.0000		0	60. 01
	6300 BLOOD STORING, PROCESSING & TRANS.			0. 3719		907	63.00
	5500 RESPI RATORY THERAPY			0. 5737	32 227, 223	130, 365	65. 00
66. 00 06	6600 PHYSI CAL THERAPY			0. 7652		58, 569	66. 00
	6601 KV HEALTH PT			0. 9294		0	66. 01
	5700 OCCUPATI ONAL THERAPY			2. 0707	75 68, 650	142, 159	67. 00
	5701 KV HEALTH OT			1. 7631		0	67. 01
	SPEECH PATHOLOGY			1. 7554		4, 082	68. 00
68. 01 06	5801 KV HEALTH ST			1. 9927	76 0	0	68. 01
70.00 07	7000 ELECTROENCEPHALOGRAPHY			0.0000		0	70. 00
71. 00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 3783	44 1, 861	704	71. 00
	7200 IMPL. DEV. CHARGED TO PATIENT			0. 4453		0	72. 00
	7300 DRUGS CHARGED TO PATIENTS			0. 4372	153, 304	67, 027	73. 00
	JTPATIENT SERVICE COST CENTERS						
	3800 RURAL HEALTH CLINIC			0.0000		0	88. 00
88. 03 08	3801 RURAL HEALTH CLINIC IV			0.0000	00	0	88. 03
	3900 FEDERALLY QUALIFIED HEALTH CENTER			0.0000	00	0	89. 00
90.00 09	9000 CLI NI C			0.6071	26 1, 623	985	90.00
	9100 EMERGENCY			1. 1775		1	91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 6229		0	92. 00
	4040 FAMILY PRACTICE			0.0000	00 0	0	93. 00
200.00	Total (sum of lines 50-94 and 96-98)				668, 120	450, 664	200. 00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)			0		201. 00
202.00	Net Charges (line 200 minus line 201)				668, 120		202. 00

Health Financial Systems	JASPER COUNTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od: From 01/01/2014		
			To 12/31/2014	Date/Time Pre 12/21/2015 2:	pared: 09 pm_
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cost	r i r r r r	Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			146, 682		30. 00

				12/21/2013 2.1	U 9 DIII
	Ti tl	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cost	Inpati ent	I npati ent	
		To Charges	Program	Program Costs	
		ŭ	Charges	(col. 1 x col.	
			ŭ	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			146, 682		30.00
31. 00 03100 NTENSI VE CARE UNI T			29, 525		31. 00
41. 00 04100 SUBPROVI DER - RF			0		41. 00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			873		43. 00
ANCI LLARY SERVI CE COST CENTERS			0,0		10.00
50. 00 05000 OPERATI NG ROOM		0. 804812	110, 511	88, 941	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 847582	9, 880	8, 374	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 494152	48, 408	23, 921	54. 00
57. 00 05700 CT SCAN		0. 000000	40, 400 N	23, 721	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 000000	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 000000	0	0	59.00
60. 00 06000 LABORATORY		0. 272578	106, 406	29, 004	60.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		0. 272378	100, 400	29, 004	60. 00
			4 044	-	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 65. 00 06500 RESPIRATORY THERAPY		0. 371905	4, 866 59, 213	1, 810	65.00
		0. 573732 0. 765265	6, 803	33, 972 5, 206	
			0, 803	5, 206	66. 00
66. 01 06601 KV HEALTH PT 67. 00 06700 OCCUPATI ONAL THERAPY		0. 929456	0	-	66. 01
		2. 070775	0	0	67. 00
67. 01 06701 KV HEALTH OT		1. 763136	0	0	67. 01
68. 00 06800 SPEECH PATHOLOGY		1. 755494	0	0	68. 00
68. 01 06801 KV HEALTH ST		1. 992776	0	0	68. 01
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 000000	0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 378344	18, 301	6, 924	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 445307	0	0	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 437215	134, 116	58, 638	73. 00
OUTPATIENT SERVICE COST CENTERS			_	_	
88. 00 08800 RURAL HEALTH CLINIC		1. 128750	0	0	88. 00
88.03 08801 RURAL HEALTH CLINIC IV		1. 429723	0	0	88. 03
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 000000	0	0	89. 00
90. 00 09000 CLI NI C		0. 607126	13, 575	8, 242	90. 00
91. 00 09100 EMERGENCY		1. 177579	23, 710	27, 920	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 622900	49, 918	31, 094	
93. 00 04040 FAMILY PRACTICE		0. 000000	0	0	93. 00
200.00 Total (sum of lines 50-94 and 96-98)			585, 707	324, 046	
201.00 Less PBP Clinic Laboratory Services-P	rogram only charges (line 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)			585, 707		202. 00

Health Financial Systems	JASPER COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151324	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 12/21/2015 2:09 pm

			To 12/31/2014	Date/Time Pre 12/21/2015 2:	
	Title XVIII Hospital		Cost	<u> </u>	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			7, 195, 660	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	2. 00 3. 00
3.00					
4.00	Outlier payment (see instructions)	i ana)		0. 000	4.00
5.00	5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5				5. 00 6. 00
	6.00 Line 2 times line 5 7.00 Sum of line 3 plus line 4 divided by line 6 0.00				
8. 00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	9. 00
10.00	Organ acquisitions			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			7, 195, 660	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		Ö	
14.00	Total reasonable charges (sum of lines 12 and 13)	ŕ		0	14. 00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for pa			0	
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(e)	payment for services of	on a cnargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17 00
18. 00	Total customary charges (see instructions)			0	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	19. 00
	instructions)	1011 44	40) (
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		7, 267, 617	21. 00
22. 00	Interns and residents (see instructions)			0	
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			4F 170	25 00
25. 00 26. 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions)	45, 172 2, 058, 800	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			5, 163, 645	
	instructions)		, , ,	.,,	
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			5, 163, 645 2, 250	
32. 00	Subtotal (line 30 minus line 31)			5, 161, 395	
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE:	S)		07 1017 070	02.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			114, 225	
35. 00	Adjusted reimbursable bad debts (see instructions)	ationa)		86, 811 107, 075	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	ctrons)		5, 248, 206	
38. 00	MSP-LCC reconciliation amount from PS&R				38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instru	ctions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions) Sequestration adjustment (see instructions)			5, 248, 206	
40. 01 41. 00	Interim payments			104, 964 4, 757, 006	
42. 00	Tentative settlement (for contractors use only)			4, 737, 000	42.00
43. 00	,				
44.00					44. 00
	§115. 2				
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90. 00
91. 00					91.00
92. 00	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	
94. 00	Total (sum of lines 91 and 93)			0	94. 00

| Provider CCN: 151324 | Period: | Worksheet E-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: | 12/21/2015 2: 09 pm Health Financial Systems JAMALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

					12/21/2015 2:0	09 pm
		Ti tl	e XVIII	Hospi tal	Cost	•
		I npati er	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3, 807, 48	6	4, 757, 006	1. 00
2.00	Interim payments payable on individual bills, either			o	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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	00/07/004	10150	al .		
3. 01	ADJUSTMENTS TO PROVIDER	08/07/2014	134, 50		0	3. 01
3. 02			1	0	0	3. 02
3. 03				0	0	3. 03
3.04				0	0	3. 04
3. 05				0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM	1		ol	0	3. 50
3. 50	ADJUSTMENTS TO PROGRAM	•		0		3. 50
3. 52			1	0		3. 52
3. 52			1	0		3. 53
3. 54			1	0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		134, 50	-		3. 99
3. 77	3. 50-3. 98)		154, 50			5. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 941, 98	6	4, 757, 006	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as				., . ,	
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	T	T	al		
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02 5. 03				0	0	5. 02 5. 03
5.03	Provider to Program			U	U	5. 03
5. 50	TENTATI VE TO PROGRAM			ol	0	5. 50
5. 51	TENTATI VE TO TROGRAM		1	o		5. 51
5. 52			1	Ö		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			o		5. 99
0. 77	5. 50-5. 98)				Ĭ	0. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
50	the cost report. (1)					2. 50
6. 01	SETTLEMENT TO PROVIDER		233, 85	5	386, 236	6. 01
6. 02	SETTLEMENT TO PROGRAM			O	0	6. 02
7.00	Total Medicare program liability (see instructions)		4, 175, 84	1	5, 143, 242	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			0	1. 00	2. 00	
8.00	Name of Contractor	I		1	ı	8.00

PITAL In Lieu of Form CMS-2552-10

Provider CCN: 151324 | Period: From 01/01/2014 | Part I

Component CCN: 15Z324 | To 12/31/2014 | Date/Time Prepared: 12/21/2015 2: 09 pm Health Financial Systems JAMALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		'			12/21/2015 2:	09 pm
				ving Beds - SNF		
		I npati er	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 161, 289		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02	ADJUSTIMENTS TO PROVIDER				0	3. 01
3. 02					0	3. 02
3. 04					0	3. 04
3. 05					0	
3.03	Provider to Program				<u> </u>	3.00
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	7.5000 THE TO THOUSE WITH		Ö		Ö	
3. 52			0		0	
3.53			0		0	3. 53
3.54			0		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 161, 289		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	T	T	T	I	
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					1
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENTATIVE TO TROVIDER		0		0	
5. 03			ĺ		0	5. 02
0.00	Provider to Program					0.00
5.50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51			Ö		Ō	
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6.02	SETTLEMENT TO PROGRAM		13, 628		0	
7.00	Total Medicare program liability (see instructions)		1, 147, 661		0	7. 00
				Contractor	NPR Date	
			`	Number	(Mo/Day/Yr)	
0.00	Name of Contractor)	1. 00	2.00	0.00
8.00	Name of Contractor	I			l	8.00

Heal th	Health Financial Systems JASPER COUNTY HOSPITAL In Lieu			u of Form CMS-2	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 151324 Period:				
			From 01/01/2014 To 12/31/2014		pared:
				12/21/2015 2:	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			951	1.00
1.00	0 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				
2.00	00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2. 00
3.00	00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		3, 622	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			48, 682, 549	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ne 20		130, 910	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of cel	rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00
	line 168	03			
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00
9.00	Sequestration adjustment amount (see instructions)			0	9. 00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
	Other Adjustment (specify)			0	1
	Balance due provider (line 8 (or line 10) minus line 30 and lin	ne 31) (see instruction	(2)	0	1

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

0 30.00 0 31.00 0 32.00

Health Financial Systems	JASPER COUNTY	IOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 151324		Worksheet E-2
			From 01/01/2014	
		Component CCN: 15Z324	To 12/31/2014	Date/Time Prepared:

	Col	mponent CCN: 15Z324	To 12/31/2014	Date/Time Pre 12/21/2015 2:	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		719, 076	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, a		455, 171	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instruct				
4. 00	Per diem cost for interns and residents not in approved teaching pr	rogram (see		0.00	4. 00
	instructions)				
5. 00	Program days		1, 006	0	5. 00
6. 00	Interns and residents not in approved teaching program (see instruc		_	0	6. 00
7.00	Utilization review - physician compensation - SNF optional method	onl y	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 174, 247	0	8. 00
9.00	Primary payer payments (see instructions)		2, 100	0	9. 00
10.00	Subtotal (line 8 minus line 9)		1, 172, 147	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable professional services)	to physician	0	0	11. 00
12. 00	Subtotal (line 10 minus line 11)		1, 172, 147	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exc	clude coinsurance	1, 064	0	13.00
	for physician professional services)		·		
14. 00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1, 171, 083	0	15. 00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16. 50
16. 55	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see instruction	ons)	0	0	18. 00
19. 00	Total (see instructions)		1, 171, 083	0	19. 00
19. 01	Sequestration adjustment (see instructions)		23, 422	0	19. 01
20. 00			1, 161, 289	0	20. 00
	Tentative settlement (for contractor use only)		0	0	21. 00
	Balance due provider/program (line 19 minus lines 19.01, 20, and 2		-13, 628	0	22. 00
23.00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				

Health Financial Systems	JASPER COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151324	From 01/01/2014	Worksheet E-3 Part V Date/Time Pre 12/21/2015 2:	pared:
	Title XVIII	Hospi tal	Cost	

				12/21/2015 2:	09 pm_
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR V - CALCULATION	ART A SERVICES - COST	RELMBURSEMENT		
1.00	Inpatient services	// 02/11/02/0 000/	TET III DOTTOE III ETT	4, 698, 122	1. 00
2. 00	Nursing and Allied Health Managed Care payment (see instruction	e)		0,070,122	2. 00
3.00	Organ acquisition	3)		0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			4, 698, 122	
5.00	,			4, 070, 122	5. 00
	Primary payer payments				
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			4, 745, 103	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
7. 00	Routi ne servi ce charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9.00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for pa			0	11.00
12.00	Amounts that would have been realized from patients liable for	payment for services o	n a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)		-		
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15.00
	instructions)		, ,		
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	7.00 Cost of physicians' services in a teaching hospital (see instructions)				17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	,			
18. 00	Direct graduate medical education payments (from Worksheet E-4,	line 49)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	,		4, 745, 103	
20. 00	Deductibles (exclude professional component)			508, 188	
21. 00	Excess reasonable cost (from line 16)			0	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)			4, 236, 915	
23. 00	Coi nsurance			7, 296	
24. 00	Subtotal (line 22 minus line 23)				
25. 00		a) (ass instructions)		4, 229, 619	
	Allowable bad debts (exclude bad debts for professional service	s) (see mstructions)		41, 373	
26. 00	Adjusted reimbursable bad debts (see instructions)			31, 443	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		28, 479	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			4, 261, 062	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
29. 99	Recovery of Accelerated Depreciation			0	
30. 00	Subtotal (see instructions)			4, 261, 062	
30. 01	Sequestration adjustment (see instructions)			85, 221	30. 01
31.00	Interim payments			3, 941, 986	31.00
32.00	Tentative settlement (for contractor use only)			0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 31, an	d 32)		233, 855	33.00
34.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	34.00
	§115. 2		•		

Health Financial Systems	JASPER COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151324	Peri od: Worksheet E-3 From 01/01/2014 Part VII To 12/31/2014 Date/Time Prepared:

			lo 12/31/2014	Date/lime Pre 12/21/2015 2:	
		Title XIX	Hospi tal	Cost	07 piii
			Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI)	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		483, 281		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		483, 281	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		483, 281	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		177, 080		8. 00
9.00	Ancillary service charges		585, 707	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10. 00
11. 00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		762, 787	0	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basi s				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
45.00	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			45.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	1
16.00	Total customary charges (see instructions)	! 6 ! 1/ -	762, 787	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only	IT line 16 exceeds	279, 506	0	17. 00
18. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only	if line 4 evecede line	0	0	18. 00
18.00	16) (see instructions)	II Time 4 exceeds fine		Ü	18.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16		483, 281	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be or			0	21.00
22. 00	Other than outlier payments	ompreted for 113 provide	0	0	22.00
	Outlier payments		o	0	
24. 00	Program capital payments		0	Ü	24.00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	1
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		483, 281	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		483, 281	0	31. 00
32.00	Deducti bl es		0	0	32. 00
33.00	Coi nsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	483, 281	0	36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		483, 281	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		483, 281	0	40. 00
41. 00			457, 245	0	
42.00	Balance due provider/program (line 40 minus line 41)		26, 036	0	
43.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				l

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provi der CCN: 151324 | Peri od: From 01/01/2014 To 12/31/2014

Period: Worksheet G From 01/01/2014 To 12/31/2014 Date/Time Prepared: 12/21/2015 2: 09 pm

					12/21/2015 2:	09 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1 00	Purpose Fund		4 00	
	CHIPDENT ACCETS	1. 00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	1, 582, 345			0	1.00
2.00	Temporary investments	1, 562, 545			0	2.00
3. 00	Notes receivable			-	0	3. 00
4. 00	Accounts receivable	4, 503, 550		o o	0	
5. 00	Other recei vable	0		o o	Ō	
6.00	Allowances for uncollectible notes and accounts receivable	0		0	0	
7.00	Inventory	1, 903, 422	. (0	0	7. 00
8.00	Prepai d expenses	0)	0	0	8. 00
9.00	Other current assets	0) (0	0	9. 00
10.00	Due from other funds	0) (0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	7, 989, 317	' (0	0	11. 00
	FI XED ASSETS				_	
12.00	Land	53, 965	1		-	1
13.00	Land improvements	0		-	0	
14.00	Accumulated depreciation	25 100 000		0	0	14.00
15. 00	Buildings	35, 190, 899	1	-	0	15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-13, 036, 694) (-	0	16. 00 17. 00
18. 00	Accumulated depreciation				0	18.00
19. 00	Fi xed equipment				0	19. 00
20. 00	Accumulated depreciation				0	20.00
21. 00	Automobiles and trucks				0	21.00
22. 00	Accumulated depreciation			-	0	22. 00
23. 00	Major movable equipment	0		-	0	23. 00
24. 00	Accumulated depreciation	0			Ö	24. 00
25. 00	Mi nor equipment depreciable	0		0	ő	25. 00
26. 00	Accumulated depreciation	l o		o o	Ō	26. 00
27. 00	HIT designated Assets	0		0	0	27. 00
28. 00	Accumul ated depreciation	0		o	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0) (o	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	22, 208, 170) (0	0	30.00
	OTHER ASSETS					
31. 00	Investments	0)	0	-	31. 00
32.00	Deposits on Leases	0) (0	0	32. 00
33. 00	Due from owners/officers	0) (0	0	33. 00
34. 00	Other assets	2, 156, 376		, i	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	2, 156, 376		<u> </u>	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	32, 353, 863		0	0	36. 00
07.00	CURRENT LIABILITIES	F 740 0F0				07.00
37. 00	Accounts payable	5, 718, 050	1			37. 00
38. 00	Salaries, wages, and fees payable Payroll taxes payable	2, 095, 248	1	-	0	38. 00
39. 00		0			0	39.00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	0			0	40. 00 41. 00
42. 00	Accel erated payments				U	42.00
43. 00	Due to other funds				0	1
44. 00	Other current liabilities	1, 532, 386			0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	9, 345, 684	•	o o		
.5. 55	LONG TERM LIABILITIES	, ,,,,,,,,,,,		-1		1
46. 00	Mortgage payable	1, 334, 706		0	0	46. 00
47. 00	Notes payable	0	1	o o		
48.00	Unsecured Loans	0		0	0	48. 00
49.00	Other long term liabilities	14, 071, 189		o	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	15, 405, 895	6	o	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	24, 751, 579) (0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	7, 602, 284				52. 00
53.00	Specific purpose fund					53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
EO 00	replacement, and expansion	7 (00 004			_	FO 00
59. 00	Total fund balances (sum of lines 52 thru 58)	7, 602, 284			0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	32, 353, 863	ή	ا ا		60.00
	17	1	1	1	1	1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					From 01/01/2014 To 12/31/2014		
		General	Fund	Speci al 1	Purpose Fund	Endowment Fund	•
	T=	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		11, 776, 725 -4, 014, 245		()	1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)		7, 762, 480				3. 00
4. 00	Additions (credit adjustments) (specify)	o	7,702,100		0	0	4. 00
5.00		0			0	0	5.00
6. 00		0			0	0	6. 00
7. 00 8. 00		0			0	0	7. 00 8. 00
9. 00					0		9. 00
10. 00	Total additions (sum of line 4-9)		0			"	10. 00
11. 00	Subtotal (line 3 plus line 10)		7, 762, 480				11.00
12. 00	MI SC	160, 196			0	0	12.00
13.00		0			0	0	13.00
14. 00 15. 00		0			0	0	14. 00 15. 00
16. 00					o		16. 00
17. 00		0			0	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		160, 196	l .	(1	18. 00
19. 00	Fund balance at end of period per balance		7, 602, 284		(19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
	T	6. 00	7. 00	8. 00			
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0		1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)				0		3. 00
4. 00	Additions (credit adjustments) (specify)		0				4. 00
5.00			0				5.00
6.00			0				6. 00
7. 00 8. 00			0				7. 00 8. 00
9. 00			0				9. 00
10.00	Total additions (sum of line 4-9)	o	_		0		10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12.00	MI SC		0				12.00
13. 00 14. 00			0				13. 00 14. 00
15. 00			0				15. 00
16. 00			0				16. 00
17. 00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0			0		18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00
	10.1001 (1.1.0 11 1111100 10)	1		1	T .	!	

 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 151324
 Period: From 01/01/2014 Parts I & II To 12/31/2014 Date/Time Prepared: 12/31/2014 Date/Time Prepare Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

			10 12/31/2014	12/21/2015 2:0	
	Cost Center Description	Inpatient	Outpati ent	Total	0 7 p
		1, 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	2, 928, 99	92	2, 928, 992	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF		0	0	3. 00
4.00	SUBPROVI DER		0	0	4. 00
5.00	Swi ng 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)	2, 928, 99	92	2, 928, 992	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	655, 37	' 5	655, 375	
12.00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	655, 37	' 5	655, 375	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	3, 584, 36		3, 584, 367	17. 00
18.00	Ancillary services	7, 295, 45		34, 824, 161	
19. 00	Outpati ent servi ces	512, 28		6, 707, 170	
20. 00	RURAL HEALTH CLINIC		0 340, 831	340, 831	
20. 03	RURAL HEALTH CLINIC IV		0 352, 681	352, 681	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	1 (50 752	21. 00
22. 00	HOME HEALTH AGENCY		1, 658, 753	1, 658, 753	
23. 00 24. 00	AMBULANCE SERVICES				23. 00 24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPICE		0 966, 979	966, 979	
27. 00	OTHER OUTPATIENT SERVICES & PRO FEES	856, 12	· ·	2, 650, 811	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	12, 248, 22			
20.00	G-3, line 1)	12, 210, 22	00,007,020	01,000,700	20.00
	PART II - OPERATING EXPENSES	<u>'</u>	·		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		36, 701, 255		29. 00
30.00	ADD (SPECIFY)		0		30. 00
31.00			0		31. 00
32.00			0		32. 00
33.00			0		33. 00
34.00			0		34.00
35.00			0		35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39. 00			0		39. 00
40.00			0		40. 00
41. 00			0		41. 00
42.00	Total deductions (sum of lines 37-41)		0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	er	36, 701, 255		43. 00
	to Wkst. G-3, line 4)	I			

Hoal th	Financial Systems JASPER COUNTY HOS	DI TAI	In Lie	u of Form CMS-2)552 10
	ENT OF REVENUES AND EXPENSES	Provider CCN: 151324	Peri od:	Worksheet G-3	332-10
			From 01/01/2014 To 12/31/2014	Date/Time Pre 12/21/2015 2:0	
1.00		20)		1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 2	28)		51, 085, 753	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			19, 676, 822	2.00
3.00	Net patient revenues (line 1 minus line 2)			31, 408, 931	3. 00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			36, 701, 255	4. 00
5. 00	Net income from service to patients (line 3 minus line 4)			-5, 292, 324	5. 00
	OTHER I NCOME			0	
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication se	ervi ces		0	8. 00
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from laundry and linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15. 00					15.00
	Revenue from sale of medical and surgical supplies to other than	n patients			16. 00
	Revenue from sale of drugs to other than patients				17. 00
18.00				0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00				0	
22. 00	The state of the s			0	
23. 00	Governmental appropriations			0	
24. 00	OTHER REVENUE			1, 184, 956	
24. 01	I NVESTMENT I NCOME			2, 523	
24. 02	OTHER NON OPERATING REVENUE			90, 600	
25. 00	Total other income (sum of lines 6-24)			1, 278, 079	25. 00
	Total (line 5 plus line 25)			-4, 014, 245	
	OTHER EXPENSES (SPECIFY)			0	
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)		l	-4, 014, 245	29. 00

CoLumn	6 Line 24	shoul d	agree with	the Workshee	t A.	column 3	line 101	1 or	subscript	as applicabl	е

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21.00

22.00

23.00

Clinic

Respiratory Therapy

Day Care Program

Homemaker Service

All Others (specify)

24.00 Total (sum of lines 1-23)

Private Duty Nursing

Health Promotion Activities

Home Delivered Meals Program

	Financial Systems LLOCATION - HHA GENERAL SERVICE	COST	JASPER COUNTY	Provi der	F	Period: From 01/01/2014	w of Form CMS-2 Worksheet H-1 Part I	
				HHA CCN:	157149 T	To 12/31/2014 Home Health	Date/Time Pre 12/21/2015 2: PPS	
			Capital Rela	ited Costs		Agency I		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Bl dgs & Fi xtures	Movable Equipment	PI ant Operation & Maintenance	Transportati on	Subtotal (cols. 0-4)	
		0	1. 00	2. 00	3. 00	4. 00	4A. 00	
1. 00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	O		1		0	1.00
	Fixtures		Ĭ					
2. 00	Capital Related - Movable Equipment	0		0			0	2.00
3. 00	Plant Operation & Maintenance	0	0	0) c		0	3.00
4. 00 5. 00	Transportation Administrative and General	0 502 102	0	0			502 102	4.00
J. UU	HHA REIMBURSABLE SERVICES	583, 102	U		,ı	,	583, 102	3.00
6.00	Skilled Nursing Care	663, 397	0	0			663, 397	
7. 00 8. 00	Physical Therapy Occupational Therapy	0	0	0	1		0	7.00
9. 00	Speech Pathology	0	O	0) c	o	0	9.00
10. 00 11. 00	Medical Social Services Home Health Aide	3, 459 226, 275	0	0			3, 459 226, 275	1
12. 00	Supplies (see instructions)	220, 273	0	0	1	-	220, 273	1
	Drugs	O	0	0			0	1
14. 00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0) <u> </u>	0	0	14.00
15. 00	Home Dialysis Aide Services	0	0	0) C	0	0	15. 00
16.00	Respiratory Therapy	0	0	0			0	16.00
17. 00 18. 00	Private Duty Nursing	0	0	0	1		0	17. 00
19. 00	Health Promotion Activities	0	o	0			0	19.00
	Day Care Program Home Delivered Meals Program	0	0	0			0	20.00
	Homemaker Service	0	0	0	1	-	0	21.00
23. 00	All Others (specify)	0	O	0			0	23.00
24. 00	Total (sum of lines 1-23)	1, 476, 233 Admi ni strati ve	Total (cols.	0) C	0	1, 476, 233	24.00
		& General	4A + 5)					
	GENERAL SERVICE COST CENTERS	5. 00	6. 00					
1. 00	Capital Related - Bldg. &							1.00
2. 00	Fixtures Capital Related - Movable		+					2.00
	Equi pment							
3. 00 4. 00	Plant Operation & Maintenance Transportation							3. 00 4. 00
5. 00	Administrative and General	583, 102						5.00
6. 00	HHA REIMBURSABLE SERVICES	433, 115	1, 096, 512					6.00
7. 00	Skilled Nursing Care Physical Therapy	433, 113	1, 096, 512					7.00
8. 00	Occupational Therapy	0	O					8. 00
9. 00 10. 00	Speech Pathology Medical Social Services	0 2, 258	0 5, 717					9.00
	Home Heal th Ai de	147, 729	374, 004					11.00
12.00	Supplies (see instructions)	0	0					12.00
13. 00 14. 00	Drugs DME	0	0					13. 00 14. 00
	HHA NONREIMBURSABLE SERVICES							
	Home Dialysis Aide Services Respiratory Therapy	0	0					15. 00 16. 00
	Private Duty Nursing	0	0					17. 00
17.00	Clinic	0	0					18. 00
18. 00		l ol	0					19.00
18. 00 19. 00	Health Promotion Activities Day Care Program		- 1					20 00
18. 00 19. 00 20. 00	Health Promotion Activities Day Care Program Home Delivered Meals Program	0	0					20. 00 21. 00
18. 00 19. 00 20. 00 21. 00 22. 00	Day Care Program	0	O					

Health Financial Systems		JASPER COUNT	Y HOSPI TAL		In Li€	eu of Form CMS-	2552-10
COST ALLOCATION - HHA STATISTICAL BAS	IS		Provi der	CCN: 151324	Peri od: From 01/01/2014	Worksheet H-1	
			HHA CCN:	157149			pared: 09 pm
					Home Health Agency I	PPS	•
	Capital Re	lated Costs					
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	PI ant Operation & Maintenance (SQUARE FEET)	(MI LEAGE)	onReconciliation	Administrative & General (ACCUM. COST)	
						1	

		Capital Rel	ated Costs					
		Bl dgs &	Movabl e	PI ant	Transportation	Reconciliation	Administrative	
		Fixtures	Equi pment	Operation &	(MI LEAGE)		& General	
			(DOLLAR VALUE)	Mai ntenance	(===)		(ACCUM. COST)	
		. ,	,	(SQUARE FEET)			,	
		1. 00	2. 00	3. 00	4.00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1. 00
	Fixtures		_			_		
2.00	Capital Related - Movable		0			0		2. 00
	Equi pment							
3.00	Plant Operation & Maintenance	0	0	0)	0		3.00
4.00	Transportation (see	0	0	O				4. 00
5. 00	instructions) Administrative and General		0			-583, 102	893, 131	5. 00
5.00	HHA REIMBURSABLE SERVICES	0	U	U	<u>'</u>	-583, 102	893, 131	5.00
6. 00	Skilled Nursing Care		0	0		1	663, 397	6. 00
7. 00	Physical Therapy		0	0		0	003, 347	7. 00
8. 00	Occupational Therapy	0	0	0		0	0	8. 00
9. 00	Speech Pathology	0	0	0			0	9. 00
10. 00	Medical Social Services	0	0	0		0	3, 459	
11. 00		0	0	Ö		0	226, 275	
12. 00	Supplies (see instructions)	0	0	Ö		0	0	12. 00
13. 00	Drugs	0	0	Ö		0	0	13. 00
14. 00		0	0	Ö		0	o	14. 00
	HHA NONREIMBURSABLE SERVICES			-	•			
15. 00	Home Dialysis Aide Services	0	0	0) C	0	0	15.00
16.00		0	0	0	o	0	0	16.00
17.00	Private Duty Nursing	0	0	0) c	0	0	17.00
18. 00	Clinic	0	0	0) c	0	0	18.00
19.00	Health Promotion Activities	0	0	0) c	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22. 00	Homemaker Service	0	0	0	0	0	0	22.00
23. 00	All Others (specify)	0	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-583, 102	893, 131	24.00
25. 00	N N	0	0	0) C		583, 102	25.00
	Worksheet H-1, Part I)							
26. 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0.000000)	0. 652874	26. 00

Health Financial Systems JA
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Peri od: Worksheet H-2
From 01/01/2014 Part I
To 12/31/2014 Date/Ti me Prepared: 12/21/2015 2: 09 pm Provider CCN: 151324 Peri od: HHA CCN: 157149 Home Health

						Agency I	PPS	
	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		0	1. 00	4. 00	4A	5. 00	7. 00	
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 18. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	0 1,096,512 0 0 5,717 374,004 0 0 0 0 0 0 0 0 0 0 0 0	58, 438 0 0 0 0 0 0 0 0 0 0 0 0	308, 948 0 0 0 0 0 0 0 0 0 0 0 0 0	367, 386 1, 096, 512 0 0 5, 717 374, 004 0 0 0 0 0 0 0	68, 686 205, 001 0 0 1, 069 69, 923 0 0 0 0 0 0 0 0 0	7.00 44,646 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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 18. 00 20. 00 21. 00
	column 26, line 1, rounded to 6 decimal places. Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	
		0.00	0.00	10.00	11 00	10.00	SUPPLY	
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 18. 00 19. 00 20. 00 21. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	8.00 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0	14. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17. 00

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

						Agency I	PPS	
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL SERVI CE	Subtotal	Intern &	Subtotal	
			RECORDS &			Residents Cost		
			LI BRARY			& Post		
						Stepdown		
		15.00	1/ 00	17.00	24.00	Adjustments	27, 00	
1.00	Administrative and General	15. 00	16. 00	17.00	24. 00 509, 143	25.00	26. 00 509, 143	1. 00
2.00	Skilled Nursing Care		C	1	1, 301, 513		1, 301, 513	
3.00	Physical Therapy	0	C	1	(0	3. 00
4. 00	Occupational Therapy	0	C		(ól ől	0	4. 00
5. 00	Speech Pathology	0	Č	1	(ol ol	0	5. 00
6. 00	Medical Social Services	l o	C	1	6, 786	ol ol	6, 786	6. 00
7.00	Home Health Aide	0	C	ol	443, 927		443, 927	7. 00
8.00	Supplies (see instructions)	0	C	ol	. (ol	0	8. 00
9.00	Drugs	o	C	ol	(o	0	9. 00
10.00	DME	0	C	0	(0	0	10.00
11. 00	Home Dialysis Aide Services	0	C	0	(0	0	11. 00
12.00	Respiratory Therapy	0	C	1 1	(0	0	12. 00
13. 00	Private Duty Nursing	0	C		(0	0	13. 00
14.00	Clinic	0	C		(0	0	14.00
15.00	Health Promotion Activities	0	C		(0	15.00
16.00	Day Care Program	0	0		(0	16.00
17. 00 18. 00	Home Delivered Meals Program Homemaker Service	0	((0	17. 00 18. 00
19. 00	All Others (specify)		C	1	(0	19. 00
20. 00	Total (sum of lines 1-19) (2)			1	2, 261, 369		2, 261, 369	
21. 00	Unit Cost Multiplier: column			ή	2, 201, 30	1	2,201,307	21. 00
200	26, line 1 divided by the sum							200
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	Allocated HHA	Total HHA					
		A&G (see Part	Costs					
		27. 00	28. 00	-				
1.00	Administrative and General	27.00	20.00					1. 00
2.00	Skilled Nursing Care	378, 180	1, 679, 693	3				2. 00
3.00	Physical Therapy	0						3. 00
4.00	Occupational Therapy	0	C					4. 00
5.00	Speech Pathology	0	C					5. 00
6.00	Medical Social Services	1, 972	8, 758					6. 00
7.00	Home Health Aide	128, 991	572, 918	1				7. 00
8.00	Supplies (see instructions)	0	C	1				8. 00
9.00	Drugs	0	C					9. 00
10.00	DME	0	C	1				10.00
11.00	Home Dialysis Aide Services Respiratory Therapy	0	0					11. 00 12. 00
12. 00 13. 00	Private Duty Nursing		C					13. 00
14. 00	Clinic		C					14. 00
15. 00	Health Promotion Activities	0	C	1				15. 00
16. 00	Day Care Program	l o	C					16. 00
17. 00	Home Delivered Meals Program	0	C					17. 00
18.00	Homemaker Service	o	C					18. 00
19.00	All Others (specify)	0	C					19. 00
20. 00	Total (sum of lines 1-19) (2)	509, 143	2, 261, 369)				20. 00
21. 00	Unit Cost Multiplier: column	0. 290569						21. 00
	26, line 1 divided by the sum							
	of column 26, line 20 minus							
	column 26, line 1, rounded to 6 decimal places.							
	To acciliai praces.	1		I				ı

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

BASIS

						Home Health Agency I	PPS	
		CAPI TAL				Ageney 1		
		RELATED COSTS	511D1 0\155			005047101105	I ALINDRY A	
	Cost Center Description	NEW BLDG & FLXT	EMPLOYEE BENEFITS	Reconciliation	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	(DOLLAR	
		FEET)	(GROSS		COST)	FEET)	VALUE)	
		,	SALARI ES)		,		,	
1.00		1.00	4.00	5A	5.00	7. 00	8. 00	1.00
1. 00 2. 00	Administrative and General Skilled Nursing Care	3, 086 0	1, 281, 244 0	1	1	3, 086 0	0	1. 00 2. 00
3. 00	Physical Therapy		C	1		0	0	3. 00
4. 00	Occupational Therapy		C		1	0	0	4. 00
5.00	Speech Pathology	O	C	o	0	0	0	5. 00
6.00	Medical Social Services	0	C	1	1 -,	0	0	6. 00
7.00	Home Health Aide	0	C		1,	0	0	7. 00
8. 00 9. 00	Supplies (see instructions) Drugs	0	C		1	0	0	8. 00 9. 00
10. 00	DME		C	1	1	0	0	10.00
11. 00	Home Dialysis Aide Services		C	1	1	0	0	11. 00
12.00	Respiratory Therapy	O	C	O	0	0	0	12. 00
13. 00	Private Duty Nursing	0	C	1	0	0	0	13. 00
14. 00	Clinic	0	C	1	1	0	0	14. 00
15. 00	Health Promotion Activities	0	C		1	0	0	15. 00
16. 00 17. 00	Day Care Program Home Delivered Meals Program		C	1	1	0	0	16. 00 17. 00
18. 00	Homemaker Service		C		1	0	0	18. 00
19.00	All Others (specify)	O	C	0	0	0	0	19. 00
20. 00	Total (sum of lines 1-19)	3, 086	1, 281, 244		1, 843, 619	3, 086	0	20. 00
21. 00	Total cost to be allocated	58, 438	308, 948	•	344, 679	44, 646	0	21. 00
22. 00	Unit cost multiplier Cost Center Description	18. 936487 HOUSEKEEPI NG	0. 241131 DI ETARY	CAFETERI A	0. 186958 NURSI NG	14. 467272 CENTRAL	O. 000000 PHARMACY	22. 00
	cost center bescription	(HOURS OF	(MEALS	(MAN	ADMI NI STRATI ON	SERVICES &	(100%	
		SERVI CE)	SERVED)	HOURS)		SUPPLY	ALLOCATION)	
					(MAN	(100%		
		9. 00	10. 00	11. 00	HOURS) 13.00	ALLOCATION) 14.00	15. 00	
1. 00	Administrative and General	6, 350	10.00			14.00	13.00	1. 00
2.00	Skilled Nursing Care	0	C			0	0	2. 00
3.00	Physi cal Therapy	0	C	1	1	0	0	3. 00
4.00	Occupational Therapy	0	C	1	1	0	0	4. 00
5. 00 6. 00	Speech Pathology Medical Social Services	0	C	1	1	0	0	5. 00 6. 00
7. 00	Home Heal th Ai de		C	1	1	0	0	7. 00
8. 00	Supplies (see instructions)		C		1	0	0	8. 00
9. 00	Drugs	Ō	C			0	0	9. 00
10.00	DME	0	C		1	0	0	10. 00
11. 00	Home Dialysis Aide Services	0	C		1	0	0	11. 00
12. 00 13. 00	Respiratory Therapy	0	C		1	0	0	12. 00 13. 00
14. 00	Private Duty Nursing		C		1	0	0	14.00
15. 00	Health Promotion Activities		C	1	1	0	0	15. 00
16.00	Day Care Program	o	C	o	0	0	0	16. 00
17. 00	Home Delivered Meals Program	0	C	1	0	0	0	17. 00
18.00	Homemaker Service	0	C	_	0	0	0	18. 00
19. 00 20. 00	All Others (specify) Total (sum of lines 1-19)	0 6, 350	C		0	0	0	19. 00 20. 00
21. 00	Total cost to be allocated	28, 425	0		0	0	0	21.00
	Unit cost multiplier	4. 476378	0. 000000	0.000000	0. 000000	0. 000000	0. 000000	
	·			•		•		

Health Financial Systems ALLOCATION OF GENERAL SERVICE COSTS T	O LILLA COCT CEN	JASPER COUNTY F	Provi der CC	N 151224	Peri od:	u of Form CMS- Worksheet H-2	
BASIS	U HHA CUST CEN	HERS STATESTICAL			From 01/01/2014	Part II	
			HHA CCN:	157149	To 12/31/2014	Date/Time Pre 12/21/2015 2:	
					Home Health	PPS	
					Agency I		
Cost Center Description	MEDI CAL	SOCIAL SERVICE					
	RECORDS &	(T1115					
	LI BRARY	(TIME					
	(TIME SPENT)	SPENT)					
	16. 00	17. 00					-
1.00 Administrative and General	10.00						1.00
2.00 Skilled Nursing Care	l o	o o					2.00
3.00 Physical Therapy	0	o					3. 00
4.00 Occupational Therapy	l o	o o					4. 00
5.00 Speech Pathology	0	o					5. 00
6.00 Medical Social Services	l o	o					6.00
7.00 Home Health Aide	0	o					7. 00
8.00 Supplies (see instructions)	0	o					8. 00
9.00 Drugs	0	o					9. 00
10. 00 DME	0	0					10.00
11.00 Home Dialysis Aide Services	0	0					11. 00
12.00 Respiratory Therapy	0	0					12. 00
13.00 Private Duty Nursing	0	0					13. 00
14. 00 Cl i ni c	0	0					14. 00
15.00 Health Promotion Activities	0	0					15. 00
16.00 Day Care Program	0	0					16. 00
17.00 Home Delivered Meals Program	0	0					17. 00
18.00 Homemaker Service	0	0					18. 00
19.00 All Others (specify)	0	0					19. 00
20.00 Total (sum of lines 1-19)	0	0					20.00
21.00 Total cost to be allocated	0	0					21. 00
22.00 Unit cost multiplier	0. 000000	0. 000000					22. 00

	Financial Systems	-C	JASPER COUNT		CON 151224		u of Form CMS-2	
PURT	TIONMENT OF PATIENT SERVICE COST	5		HHA CCN:	CCN: 151324 157149	Period: From 01/01/2014 To 12/31/2014	Worksheet H-3 Part I Date/Time Prep	
				T: +1	o VVIIII	Home Heel th	12/21/2015 2: 0 PPS	
				11 11	e XVIII	Home Health Agency I	PPS	
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	(from Wkst. H-2 Part I)	Ancillary Costs (from	Costs (cols. + 2)	1	Per Visit (col. 3 ÷ col.	
		20, 11110	11 2, 141 (1)	Part II)	1 2)		4)	
	DADT I COMPUTATION OF LECCED	0	1.00	2.00	3.00	4.00	5. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE I	PRUGRAM CUSI, A	GGREGATE OF TH	E PRUGRAM LIN	MITATION COST, OF	ζ	
	Cost Per Visit Computation							
00	Skilled Nursing Care	2.00			1, 679, 69			1. (
00	Physical Therapy Occupational Therapy	3. 00 4. 00		312, 412 197, 105	1		103. 83 297. 74	2. (3. (
00	Speech Pathology	5. 00		48, 978			277. 74 272. 10	
00	Medical Social Services	6. 00			8, 7!		398. 09	
00	Home Health Aide	7. 00			572, 9°		66. 65	
00	Total (sum of lines 1-6)		2, 261, 369	558, 495				7. (
			1		Program Visi			
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	art B to Subject to		
	oost denter bescription	0031 Eriii 13	OBSA NO. (1)	Tui t A	Deducti bl es Coi nsurance	& Deductibles		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Limitation Cost Computation	T			T			
00 01	Skilled Nursing Care Skilled Nursing Care		23844 28100	0	l .	0		8. (8. (
02	Skilled Nursing Care		29140	0		94		8.
03	Skilled Nursing Care		99915	Ö	_	19		8.
00	Physi cal Therapy		23844	0		0		9.
01	Physical Therapy		28100	0				9.
02	Physi cal Therapy		29140	0		58		9.
03	Physical Therapy		99915	0		0		9. 10.
. 00	Occupational Therapy Occupational Therapy		23844 28100	0		48		10.
. 02	Occupational Therapy		29140	0		9		10.
. 03	Occupational Therapy		99915	0		0		10.
. 00	Speech Pathology		23844	0		0		11.
. 01	Speech Pathology		28100	0	l .	39		11.
. 02	Speech Pathology		29140	0		0		11.
. 03	Speech Pathology Medical Social Services		99915 23844	0		0		11. 12.
. 00	Medical Social Services		28100	0		18		12.
. 02	Medical Social Services		29140	0		0		12.
. 03	Medical Social Services		99915	Ö	l .	0		12.
. 00	Home Health Aide		23844	0		0		13.
. 01	4		28100	0				13.
	Home Health Aide		29140	0	15			13.
	Home Heal th Aide		99915	0		11		13.
. 00	Total (sum of lines 8-13) Cost Center Description	From Wkst H_2	Facility Costs	Shared	8, 94 Total HHA		Ratio (col. 3	14.
	oost conten bescription	Part I, col.	(from Wkst.		Costs (cols.		÷ col . 4)	
		28, line	H-2, Part I)	Costs (from	+ 2)	Record)	Í	
		0	1.00	Part II) 2.00	3. 00	4. 00	5. 00	
	Supplies and Drugs Cost Computa		1.00	2.00	0.00	1.00	0.00	
. 00	Cost of Medical Supplies	8. 00				0 0		
	Cost of Drugs	9. 00	0	0	1	0 0	0. 000000	

	Financial Systems		JASPER COUNT				u of Form CMS-2	
PPORT	FIONMENT OF PATIENT SERVICE COST:	S		Provi der	CCN: 151324	Period: From 01/01/2014	Worksheet H-3 Part I	
				HHA CCN:	157149	To 12/31/2014	Date/Time Pre 12/21/2015 2:	
				Ti tl	e XVIII	Home Health Agency I	PPS	ол рііі
			Program Visits		Cost of	Agency I		
			Par	t R	Servi ces	Part B		
	Cost Center Description	Part A	Not Subject to Deductibles &	Subject to Deductibles &	Part A	Not Subject to Deductibles &	Deductibles &	
		6. 00	Coi nsurance	Coi nsurance 8. 00	9. 00	Coi nsurance 10.00	Coi nsurance	
	PART I - COMPUTATION OF LESSER		7.00 PROGRAM COST A				11. 00	
	BENEFICIARY COST LIMITATION	OI AGGILLOATE I	TROOTERIN COST, A	SOREONIE OF TH	E I KOOKAWI EI I	WITATION COST, OF	`	
	Cost Per Visit Computation							İ
00	Skilled Nursing Care	C				0 1, 136, 902		1. (
00	Physi cal Therapy	C	.,			0 195, 512		2. 0
00	Occupati onal Therapy	C	457			0 136, 067		3.0
00	Speech Pathology	C	139			0 37, 822		4. (
00	Medical Social Services	C	18			0 7, 166		5. (
00	Home Heal th Aide	C	3, 301			0 220, 012		6. (
00	Total (sum of lines 1-6)		8, 942			0 1, 733, 481		7. (
	Cost Center Description	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Limitation Cost Computation	6.00	7.00	6.00	9.00	10.00	11.00	
00	Skilled Nursing Care							8.
01	Skilled Nursing Care							8.
02	Skilled Nursing Care							8.
03	Skilled Nursing Care							8.
00	Physical Therapy							9.
01	Physical Therapy							9.
02	Physical Therapy							9.
03	Physical Therapy							9.
0.00	Occupational Therapy							10.
). 01	Occupational Therapy							10.
). 02	Occupational Therapy							10.
								10.
. 03	Occupational Therapy							
. 00	1 .							11.
. 01	Speech Pathology							11.
. 02	1 .							11.
. 03	Speech Pathology							11.
. 00	Medical Social Services							12.
. 01	Medical Social Services							12.
. 02	Medical Social Services							12.
. 03	Medical Social Services							12.
. 00	Home Health Aide							13.
. 01	Home Health Aide							13.
3. 02	Home Health Aide							13.
. 03								13.
. 00	Total (sum of lines 8-13)	D			C+ -£			14.
		Prog	ram Covered Cha	rges	Cost of Services			
			Par			Part B		
	Cost Center Description	Part A	Not Subject to	Subject to	Part A	Not Subject to		
			Deductibles &			Deductibles &	Deductibles &	
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
		6. 00	7. 00	8. 00	9. 00	10. 00	11. 00	
	Supplies and Drugs Cost Computa			=			=	1
5. 00		C		0		0 0		
1 1()	Cost of Drugs		0	0		0	1 0	16.

APPORT	IONMENT OF PATIENT SERVICE COST	S		Provi der CCN	N: 151324	Peri od: From 01/01/2014	Worksheet H- Part I	3
				HHA CCN:	157149	To 12/31/2014		epared:
				Title X	VIII	Home Health Agency I	PPS	07
	Cost Center Description	Total Program				/ Agency 1		
		Cost (sum of cols. 9-10)						
		12. 00				-		_
	PART I - COMPUTATION OF LESSER		OGRAM COST, AGGR	EGATE OF THE P	ROGRAM LII	MITATION COST, OR		
	BENEFICIARY COST LIMITATION		·			·		
	Cost Per Visit Computation							
1. 00	Skilled Nursing Care	1, 136, 902						1.0
2.00	Physi cal Therapy	195, 512						2.0
3.00	Occupational Therapy	136, 067						3. 0
4. 00 5. 00	Speech Pathology Medical Social Services	37, 822 7, 166						4. C
5. 00 6. 00	Home Health Aide	220, 012						6. 0
7. 00	Total (sum of lines 1-6)	1, 733, 481						7.0
	Cost Center Description	.,	,			,		
	·	12. 00						
	Limitation Cost Computation							
8. 00	Skilled Nursing Care							8.0
8. 01	Skilled Nursing Care							8.0
3. 02	Skilled Nursing Care Skilled Nursing Care							8. C
8. 03 9. 00	Physical Therapy							9.0
9. 01	Physical Therapy							9.0
9. 02	Physical Therapy							9. (
9. 03	Physical Therapy							9. 0
10.00	Occupational Therapy							10.0
10. 01	Occupational Therapy							10. (
10. 02	Occupational Therapy							10.0
0. 03	Occupational Therapy							10. (
11. 00 11. 01	Speech Pathology Speech Pathology							11. (
1. 01	Speech Pathology							11. (
11. 02	Speech Pathology							11. (
2. 00	Medical Social Services							12. (
12. 01	Medical Social Services							12. (
12. 02	Medical Social Services							12. (
12. 03	Medical Social Services							12. 0
13.00	Home Health Aide							13. 0
13. 01	Home Health Aide							13. (
13. 02 13. 03	Home Health Aide Home Health Aide							13. 0
13.03	Total (sum of lines 8-13)							14. 0

Heal th	Health Financial Systems JASPER COU					In Lie	In Lieu of Form CMS-2552-10		
APPOR	TIONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 151324	Peri od:	Worksheet H-3		
				HHA CCN:	157149	From 01/01/2014 To 12/31/2014			
					e XVIII	Home Health Agency I	PPS		
	Cost Center Description	From Wkst. C.	Cost to Charge	Total HHA	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 COST	T OF HHA SERVIC	CES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	NTS			
1.00	Physi cal Therapy	66. 00	0. 765265	408, 240	312, 4	12 col. 2, line 2	. 00	1. 00	
1.01	Physical Therapy 1	66. 01	0. 929456	0		Ocol. 2, line 2	. 01	1. 01	
2.00	Occupational Therapy	67. 00	2. 070775	95, 184	197, 1	05 col. 2, line 3	. 00	2. 00	
2.01	Occupational Therapy 1	67. 01	1. 763136	0		Ocol. 2, line 3	. 01	2. 01	
3.00	Speech Pathology	68. 00	1. 755494	27, 900	48, 9	78 col. 2, line 4	. 00	3. 00	
3.01	Speech Pathology 1	68. 01	1. 992776	0		0 col. 2, line 4	. 01	3. 01	
4.00	Cost of Medical Supplies	71. 00	0. 378344	0		0 col. 2, line 1	5. 00	4.00	
5. 00	Cost of Drugs	73. 00	0. 437215	0		0 col. 2, line 1	6. 00	5. 00	

CULATION OF HHA REIMBURSEMENT SETTLEMENT	Provi der	CCN: 151324	Peri od:	worksheet H-4	
	HHA CCN:	157149	From 01/01/2014 To 12/31/2014		
	Ti tl	e XVIII	Home Health Agency I	PPS	<u> </u>
				t B	
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2. 00	3. 00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOM	MARY CHARGE	S			
Reasonable Cost of Part A & Part B Services				1 0	4.
Reasonable cost of services (see instructions) Total charges			0 0		
Customary Charges			0 0		1
Amount actually collected from patients liable for payment for	servi ces		0 0	0	1 :
on a charge basis (from your records)					
Amount that would have been realized from patients liable for patients on a charge basis had such payment been made in act with 42 CFR §413.13(b)			0 0	0	1
Ratio of line 3 to line 4 (not to exceed 1.000000)		0. 00000	0. 000000	0. 000000	1
Total customary charges (see instructions) Excess of total customary charges over total reasonable cost (complete		0 0	0	
only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete only 1 exceeds line 6)			0 0	0	
Primary payer amounts			0 0	0	
			Part A	Part B	
			Servi ces	Servi ces	\vdash
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1. 00	2. 00	\vdash
Total reasonable cost (see instructions)			0	0	1
Total PPS Reimbursement - Full Episodes without Outliers			0		
Total PPS Reimbursement - Full Episodes with Outliers			0	63, 505	
70 Total PPS Reimbursement - LUPA Episodes			0	13, 969	
70 Total PPS Reimbursement - PEP Episodes			0	6, 536	
00 Total PPS Outlier Reimbursement - Full Episodes with Outliers 00 Total PPS Outlier Reimbursement - PEP Episodes			0	44, 011	
00 Total Other Payments			0	Ö	
00 DME Payments			0	0	
Oxygen Payments			0	0	1
Prosthetic and Orthotic Payments			0	1	1 -
Part B deductibles billed to Medicare patients (exclude coinsur	rance)		_	0	
OD Subtotal (sum of lines 10 thru 20 minus line 21)			0	985, 179	
00 Excess reasonable cost (from line 8) 00 Subtotal (line 22 minus line 23)			0	0 985, 179	
00 Coinsurance billed to program patients (from your records)			0	905, 179	
00 Net cost (line 24 minus line 25)			0	985, 179	
				100,	2
Reimbursable bad debts (from your records)	structions)				2
00 Reimbursable bad debts (from your records) 00 Reimbursable bad debts for dual eligible beneficiaries (see ins	271		0		
00 Reimbursable bad debts for dual eligible beneficiaries (see ins 00 Total costs – current cost reporting period (line 26 plus line	21)		1 0	0	
Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			_		1 3
Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	005 170	
Reimbursable bad debts for dual eligible beneficiaries (see instructions) Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions)			0	985, 179	3
Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions)			0 0 0	985, 179 19, 704	3
Reimbursable bad debts for dual eligible beneficiaries (see instructions) Reimbursable bad debts for dual eligible beneficiaries (see instructions) Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions) Interim payments (see instructions)			000000000000000000000000000000000000000	985, 179	3:
Reimbursable bad debts for dual eligible beneficiaries (see ins Total costs - current cost reporting period (line 26 plus line OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) Subtotal (see instructions) Sequestration adjustment (see instructions)			000000000000000000000000000000000000000	985, 179 19, 704 965, 475	3:

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO Provide Provided PROGRAM BENEFICIARIES

				Home Health Agency I	PPS	
		Inpatien	t Part A		Part 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			0	965, 475 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	11 ogram to 11 ovraor			0	0	3. 01
3. 02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
	Provider to Program	·				
3.50				0	0	3. 50
3. 51 3. 52				0	0	3. 51 3. 52
3.52				0		3. 52
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			0	965, 475	4. 00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider	1		_	_	
5. 01				0	0	5. 01
5. 02 5. 03				0	0	5. 02 5. 03
5.03	Provider to Program			O ₁	0	5. 03
5.50	110vi doi 10 110gi diii			0	0	5. 50
5. 51				0	0	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6.02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)			0	965, 475	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
0.00	N 60 1	()	1. 00	2. 00	0.00
8. 00	Name of Contractor	I		T	1 1	8. 00

			Hospi ce (CON: 151519	0 12/31/2014	12/21/2015 2:	
					Hospi ce I	12/21/2013 2.	07 piii
		Salaries (from	Empl oyee	Transportati or		Other	
			Benefits (from		Services (from		
		,	Wkst. K-2)		Wkst. K-3)		
		1.00	2.00	3.00	4. 00	5. 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	0)	0	0	3. 00
4.00	Transportation - Staff	0	0) (0	0	4. 00
5.00	Volunteer Service Coordination	0	0) (0	0	5. 00
6.00	Administrative and General	19, 141	0)	0	289, 325	6. 00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0	0	1		0	7. 00
8.00	Inpatient - Respite Care	0	0)	0	0	8. 00
	VI SI TI NG SERVI CES	,					
9. 00	Physician Services	0	0			0	9. 00
10. 00	Nursing Care	39, 122	0	1	0	0	10. 00
11. 00	Nursing Care-Continuous Home Care	0	0		0	0	11. 00
12. 00	Physi cal Therapy	0	0	1	0	0	12.00
13.00	Occupational Therapy	0	0	1	0	0	13.00
14.00	Speech/ Language Pathology	0	0	1	0	0	14.00
15. 00	Medical Social Services	65, 725	Ü		0	0	15. 00
16.00	Spiritual Counseling	0	Ü		0	0	16.00
17. 00	Di etary Counsel i ng	0	0		0	0	17. 00
18.00	Counseling - Other	4 (10	0		0	0	18.00
19. 00	Home Health Aide and Homemaker	4, 618	0		0	0	19. 00
20. 00 21. 00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	20. 00 21. 00
21.00	Other OTHER HOSPICE SERVICE COSTS	l o	U	1	<u> </u>	U	21.00
22. 00	Drugs, Biological and Infusion Therapy		0		0	0	22. 00
23. 00	Anal gesi cs	0	0			0	23. 00
24. 00	Sedatives / Hypnotics	0	0		-	0	24.00
25. 00	Other - Specify	0	0		, i	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0		, i	0	26.00
27. 00	Patient Transportation	0	0	1		0	27. 00
28. 00	Imaging Services	0	0			0	28. 00
29. 00	Labs and Diagnostics	0	0	1		0	29.00
30.00	Medical Supplies	0	0	1	o o	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	Ö	0		-	0	31. 00
32. 00	Radi ati on Therapy	0	0		-	0	32. 00
33. 00	Chemotherapy	o	0		o o	0	33. 00
34. 00	Other	0	0	•	o o	0	34. 00
	HOSPI CE NONREI MBURSABLE SERVI CE	-1					
35.00	Bereavement Program Costs	0	C) (0	0	35. 00
36.00	Volunteer Program Costs	o	O		0	0	36. 00
37.00	Fundrai si ng	o	0) (0	0	37. 00
38.00	Other Program Costs	o	0) (0	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	128, 606	0) (0	289, 325	39. 00

Health Financial Systems	JASPER COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 151324	Period: Worksheet K

Hospice CCN: 151519 From 01/01/2014 To 12/31/2014 Date/Time Prepared: 12/21/2015 2:09 pm

			Hospi ce (CN: 151519 10	0 12/31/2014	12/21/2015 2:	
					Hospi ce I	12/21/2010 2.	07 piii
		Total (cols.	Recl assi fi cati	Subtotal (col.	Adjustments	Total (col. 8	
		1-5)	on	6 ± col. 7)	,	± col. 9)	
		6.00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0	0	0	0	1. 00
2.00	Capital Related Costs-Movable Equip.	0	0	0	0	0	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	308, 466	0	308, 466	0	308, 466	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7. 00
8.00	Inpatient - Respite Care	0	0	0	0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0	0	0	0	9. 00
10.00	Nursing Care	39, 122	0	39, 122	0	39, 122	10.00
11. 00	Nursing Care-Continuous Home Care	0	0	0	0	0	11. 00
12.00	Physi cal 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	14. 00
15. 00	Medical Social Services	65, 725	0	65, 725	0	65, 725	15. 00
16.00	Spiritual Counseling	0	0	0	0	0	16. 00
17. 00	Di etary Counseling	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	4, 618	0	4, 618	0	4, 618	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	0	0		0	0	22. 00
23. 00	Anal gesi cs	0	0	1	0	0	23. 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	0	26. 00
27. 00	Pati ent Transportation	0	0	0	0	0	27. 00
28. 00	I maging Services	0	0	0	0	0	28. 00
29. 00	Labs and Diagnostics	0	0	0	0	0	29. 00
30. 00	Medical Supplies	0	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	33. 00
34.00	Other	0	0	0	0	0	34. 00
	HOSPICE NONREIMBURSABLE SERVICE	_		_1	_1	_	
	Bereavement Program Costs	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)	417, 931	0	417, 931	0	417, 931	39.00

Health Financial Systems	JASPER COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES	Provi der CCN: 151324	Period: Worksheet K-1 From 01/01/2014

Hospi ce CCN: 151519 To 12/31/2014 Date/Ti me Prepared:

			1.000		.0 12/01/2011	12/21/2015 2:	09 pm
					Hospi ce I		
	·	Admi ni strator	Di rector	Soci al	Supervi sors	Nurses	
				Servi ces	'		
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
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	0	O		0 0	0	3. 00
4.00	Transportation - Staff	0	0		0 0	0	4.00
5.00	Volunteer Service Coordination	o	0		0 0	0	5.00
6.00	Administrative and General	19, 141	0		0 0	0	6. 00
	I NPATI ENT CARE SERVI CE			•			
7.00	Inpatient - General Care	0	O		0 0	0	7.00
8.00	Inpatient - Respite Care	O	0		0 0		1
	VI SI TI NG SERVI CES						
9.00	Physician Services	0	0		0 0	0	9.00
10. 00	Nursing Care	0	0	l	0 0		
11. 00	Nursing Care-Continuous Home Care	0	0		0 0	0,,,,22	1
12. 00	Physical Therapy	0	0		0 0		
13. 00	Occupational Therapy	0	0		0 0	0	
14. 00	Speech/ Language Pathology		0		0 0	0	
15. 00	Medical Social Services		0	65, 72	-	0	
16. 00	Spiritual Counseling		0		0 0	0	
17. 00	Di etary Counseling		0		0 0	0	
18. 00	Counseling - Other		0		0 0	0	
19. 00	Home Health Aide and Homemaker		0		0 0	0	
20. 00	HH Ai de & Homemaker - Cont. Home Care		0		0 0	_	
21. 00	Other		0	1	0 0		
21.00	OTHER HOSPICE SERVICE COSTS	U U		'l	0	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							25. 00
	Other - Specify						26.00
26. 00	Durable Medical Equipment/Oxygen		0		0	_	
27. 00	Patient Transportation	0	U	(0	0	
28. 00	I maging Services	0	Ü	2	0	0	
29. 00	Labs and Diagnostics	0	0)	0	0	
30. 00	Medical Supplies	0	0)	0	0	
31. 00	Outpatient Services (including E/R Dept.)	0	0)	0	0	
32. 00	Radiation Therapy	0	0)	0	0	
33.00	Chemotherapy	0	0		0	_	
34.00	Other	0	0)	0 0	0	34. 00
	HOSPICE NONREIMBURSABLE SERVICE						
	Bereavement Program Costs	0	0)	0	0	
36.00	Volunteer Program Costs	0	0)	0	0	
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)	19, 141	0	65, 72	5 0	39, 122	39. 00
		•					

Heal th	Financial Systems	JASPER COUNTY HOSPITAL				In Lieu of Form CMS-2552-1		
HOSPI (CE COMPENSATION ANALYSIS SALARIES AND WAGES			Peri od: From 01/01/2014	Worksheet K-1			
			Н	Hospi ce C		To 12/31/2014	Date/Time Pre 12/21/2015 2:	pared: 09 pm
						Hospi ce I		
	·	Total	Ai	i des	All-Other	Total (1)		
		Therapi sts						
		6.00	7.	'. 00	8. 00	9. 00		
	GENERAL SERVICE COST CENTERS							
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			0		0 0		3. 00
4.00	Transportation - Staff			0		0 0		4.00
5.00	Volunteer Service Coordination			0		0 0		5. 00
4 00	Administrative and Conseq		l .	0		10 141		/ 00

						12/21/2015 2:	09 pm
					Hospi ce I		
	·		CAPI TAL RE	LATED COST	·		
		NET EXPENSES	BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATION	
		FOR COST	FI XTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON			MAI NT.		
		0	1.00	2. 00	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capital Related Costs-Movable Equip.	أم	_		o		2.00
3.00	Plant Operation and Maintenance	أم	0		o o		3. 00
4. 00	Transportation - Staff		0				4. 00
5. 00	Volunteer Service Coordination		0			_	5. 00
6.00	Administrative and General	308, 466	0		0 0		6.00
0.00	I NPATI ENT CARE SERVI CE	300, 400			0 0		0.00
7. 00	Inpatient - General Care	O	0		0 0	0	7.00
8. 00	Inpatient - Respite Care		0		0 0		8.00
0.00	VI SI TI NG SERVI CES	<u> </u>			0 0		0.00
9. 00	Physician Services	O	0		0 0	0	9. 00
10. 00	Nursing Care	39, 122	0		0 0		10.00
11. 00	Nursing Care-Continuous Home Care	37, 122	0			_	11.00
12. 00	Physical Therapy	0	0		0 0		12.00
13. 00	Occupational Therapy	0	0		0 0		13.00
		0	0		0 0	_	14.00
14. 00	Speech/ Language Pathology	/ F 725	0		0 0	_	15.00
15. 00 16. 00	Medical Social Services	65, 725	0		0 0		16.00
	Spiritual Counseling	U	0		-	_	17. 00
17. 00	Di etary Counsel i ng	U	0		9	_	
18.00	Counseling - Other	4 (10	0		0	0	18.00
19.00	Home Health Aide and Homemaker	4, 618	0		0	_	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	_	20.00
21. 00	Other	0	0		0 0	0	21. 00
22.00	OTHER HOSPICE SERVICE COSTS	1 0	0			0	1 22 20
22. 00	Drugs, Biological and Infusion Therapy	0	0		0	_	22. 00
23. 00	Anal gesi cs	0	0		0	_	23. 00
24. 00	Sedatives / Hypnotics	0	0		0	0	24. 00
25. 00	Other - Specify	0	0		0	_	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	0		0	_	26. 00
27. 00	Pati ent Transportation	0	0		0		27. 00
28. 00	I maging 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	_	30. 00
31. 00	Outpatient Services (including E/R Dept.)	0	0		0	_	31. 00
32. 00	Radiation Therapy	0	0		0	_	32. 00
33.00	Chemotherapy	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		35. 00
36.00	Volunteer Program Costs	0	0		0		36. 00
37. 00	Fundrai si ng	0	0		0	0	37. 00
38. 00	Other Program Costs	0	0		0		38. 00
39. 00	Total (sum of lines 1 thru 38)	417, 931	0		0 0	0	39. 00

Health Financial Systems

COST ALLOCATION - HOSPICE GENERAL SERVICE COST JASPER COUNTY HOSPITAL

			Hospi ce (CN: 151519	10 12/31/2014	Date/II me Prepared: 12/21/2015 2:09 pm
					Hospi ce I	12/21/2013 2:07 0111
		VOLUNTEER	SUBTOTAL	ADMI NI STRATI V	ETOTAL (col. 5A	
		SERVI CES	(cols. 0 - 5)	& GENERAL	± col. 6)	
		COORDI NATOR	(
		5. 00	5A	6.00	7. 00	
	GENERAL SERVICE COST CENTERS					
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	308, 466	308, 46	6	6. 00
	INPATIENT CARE SERVICE					
7.00	Inpatient - General Care	0		1	0 0	7. 00
8.00	Inpatient - Respite Care	0	C	1	0 0	8. 00
	VISITING SERVICES					
9. 00	Physi ci an Servi ces	0	1	1	0 0	
10. 00	Nursi ng Care	0	39, 122	110, 24	4 149, 366	10. 00
11. 00	Nursing Care-Continuous Home Care	0	C	1	0 0	11. 00
12. 00	Physi cal Therapy	0	C	1	0 0	12. 00
13. 00	Occupational Therapy	0	C		0 0	13. 00
14. 00	Speech/ Language Pathology	0	C		0 0	14. 00
15. 00	Medical Social Services	0	65, 725	185, 20	9 250, 934	15. 00
16. 00	Spiritual Counseling	0	C	1	0 0	16. 00
17. 00	Di etary Counsel i ng	0			0 0	17. 00
18. 00	Counseling - Other	0	0	1	0 0	18. 00
19. 00	Home Health Aide and Homemaker	0	4, 618	1		19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0		1	0 0	20.00
21. 00	Other	0	C		0 0	21. 00
22.00	OTHER HOSPICE SERVICE COSTS					22.00
22. 00	Drugs, Biological and Infusion Therapy	0	C	1	0 0	22. 00
23. 00	Anal gesi cs	0			-	23. 00
24. 00	Sedatives / Hypnotics	0			າ າ	24. 00
25. 00	Other - Specify	0			0 0	25. 00
26. 00 27. 00	Durable Medical Equipment/Oxygen Patient Transportation	0			0 0	26. 00 27. 00
28. 00	Imaging Services	0		•	0 0	27.00
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		1		31. 00
32. 00	Radi ati on Therapy					32.00
33. 00	Chemotherapy	0		1		33. 00
34. 00	Other			1		34.00
34.00	HOSPI CE NONREI MBURSABLE SERVI CE		1	1	<u> </u>	34.00
35. 00	Bereavement Program Costs	0			0 0	35. 00
36. 00	Volunteer Program Costs				0 0	36. 00
37. 00	Fundrai si ng	1		I		37. 00
38. 00	Other Program Costs	0		1		38. 00
	Total (sum of lines 1 thru 38)	0	417, 931	1	417, 931	39. 00
		-		•		1

| Provider CCN: 151324 | Period: | Worksheet K-4 | Part II | Date/Time Prepared: | 12/21/2015 2: 09 pm

			,			12/21/2015 2:	09 pm
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.		COORDI NATOR	
		,	ĺ	FT.)`		(HOURS)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS				•		
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	i o	0				3. 00
4. 00	Transportation - Staff	0	0		0		4. 00
5. 00	Volunteer Service Coordination					0	5. 00
						0	•
6. 00	Administrative and General	0		1	J U	0	6. 00
7.00	I NPATI ENT CARE SERVI CE	1		1		0	7 00
7.00	Inpatient - General Care	0			0		7. 00
8. 00	Inpatient - Respite Care	0	0	1	0	0	8. 00
	VI SI TI NG SERVI CES	ı		ı	1		
9.00	Physi ci an Servi ces	0	1		0	0	9. 00
10. 00	Nursing Care	0	0		0	0	10. 00
11. 00	Nursing Care-Continuous Home Care	0	0		0	0	11. 00
12.00	Physi cal Therapy	0	0		0	0	12. 00
13.00	Occupational Therapy	0	0		0	0	13.00
14.00	Speech/ Language Pathology	0	0		0	0	14. 00
15.00	Medical Social Services	0	0		0	0	15. 00
16.00	Spiritual Counseling	0	l o		0	0	16. 00
17. 00	Di etary Counsel i ng	0	0		0	0	17. 00
18. 00	Counseling - Other	0	0		0	0	18. 00
19. 00	Home Health Aide and Homemaker	i o	0		0	0	19. 00
20. 00	HH Ai de & Homemaker - Cont. Home Care	l o	ĺ	•	o o	Ö	20.00
21. 00	Other	0	Ö			0	21.00
21.00	OTHER HOSPICE SERVICE COSTS			·	5	0	21.00
22. 00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22. 00
23. 00	Anal gesi cs		0	•		0	23. 00
24. 00	Sedatives / Hypnotics					0	24.00
		0				0	
25. 00	Other - Specify	0	1				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	I maging 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	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	Volunteer Program Costs	0	o	•	0	0	36. 00
37. 00	Fundrai si ng	0	l o	1	0	0	37. 00
38. 00	Other Program Costs	n	١	1	0	0	38. 00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)	1 0	ا آ			0	39. 00
	Unit Cost Multiplier	0. 000000	0. 000000	0. 00000	0. 000000	_	
40.00	Join C 003C mar crprior	0.00000	0.00000	0.00000	0.00000	0.000000	1 .0.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS JASPER COUNTY HOSPITAL

RECONCILIATION/MOM IN STRATILYE & GENERAL (ACC. OST)					Hospi ce I	12/21/2013 2	. 07 рііі
Benefal Service COST CENTERS			RECONCILIATION	ADMI NI STRATI VE	1.0001.001		
CACC. COST) CAPITAL SERVICE COST CENTERS CAPITAL SERVICE CENTERS CAPITAL S							
CEMERAL SERVICE COST CENTERS							
			6A				
1.00		GENERAL SERVICE COST CENTERS					
1.00	1.00	Capital Related Costs-Bldg and Fixt.	0				1.00
1.00	2.00	Capital Related Costs-Movable Equip.	0				2. 00
4.00	3.00		0				3.00
5. 00 Volunteer Service Coordination -308,466 109,465 6. 00 109,465 6. 00 109,465 6. 00 109,465 7.			0				4. 00
Administrative and General -308,466 109,465		· ·					
INPATIENT CARE SERVICE			-308, 466	109, 465			•
Type				1217120			
Description	7.00		0	0			7.00
VISITING SERVICES		1 .	0				•
9,00 Physician Services							
10.00 Nursing Care	9.00		0	0			9.00
12.00 Physical Therapy 0 0 0 13.00 0 14.00 0 15.00 0 15.00 0 15.00 15.00 0 0 15.00 0 15.00 0 15.00 0 15.00 0 15.00 0 0 15.00 0 15.00 0 0 15.00 0 0 15.00 0 0 0 0 0 0 0 0 0	10.00		o	39, 122			10.00
12.00 Physical Therapy 0 0 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 0 13.00 13.00 0 13.00	11. 00	Nursing Care-Continuous Home Care	o	0			11. 00
13.00	12.00		o	0			12. 00
14.00 Speech/ Language Pathology 0 0 14.00 15.00 Medical Social Services 0 65,725 15.00 16.00 Spiritual Counseling 0 0 0 17.00 Dietary Counseling 0 0 0 18.00 Counseling - Other 0 0 0 19.00 Home Heal th Aide and Homemaker 0 4,618 19.00 19.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 10.00 Other 0 0 0 10.00 Other - Specify 0 0 0 21.00 Other - Specify 0 0 0 24.00 Sedatives / Hypnotics 0 0 0 25.00 Other - Specify 0 0 0 26.00 Drable Medical Equipment/Oxygen 0 0 27.00 Patient Transportation 0 0 0 28.00 Imaging Services 0 0 0 29.00 Labs and Diagnostics 0 0 0 30.00 Medical Supplies 0 0 0 31.00 Outpatient Services (including E/R Dept.) 0 0 32.00 Radiation Therapy 0 0 0 33.00 Chemotherapy 0 0 0 34.00 Other Orogram Costs 0 0 37.00 Fundraising 0 0 0 37.00 Outpatient Services Outp	13.00		o	0			13. 00
15. 00 Medical Social Services 0 65,725 15. 00 Spiritual Counseling 0 0 0 0 16. 00 17. 00 17. 00 18. 00 Counseling 0 0 0 0 0 17. 00 18. 00 Counseling 0 0 0 0 0 18. 00 Counseling 0 0 0 0 0 18. 00 Counseling 0 0 0 0 0 0 0 0 0	14.00		o	0			14. 00
17. 00 Di etary Counseling 17. 00 18. 00	15.00		o	65, 725			15. 00
17. 00 Di etary Counseling 17. 00 18. 00	16.00	Spiritual Counseling	o	0			16. 00
18.00 Counseling - Other 0 0 0 18.00 19.00	17. 00		o	0			17. 00
20.00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 0 21.00	18.00		0	0			18. 00
21.00 Other	19.00	Home Health Aide and Homemaker	0	4, 618			19. 00
DTHER HOSPICE SERVICE COSTS Drugs, Biological and Infusion Therapy O O O O O O O O O	20.00	HH Aide & Homemaker - Cont. Home Care	0	0			20. 00
22. 00 Drugs, Biological and Infusion Therapy 0 0 23. 00 23. 00 Anal gesics 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 0 31. 00 32. 00 Radiation Therapy 0 0 32. 00 33. 00 Chemotherapy 0 0 33. 00 4. 00 Other 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 35. 00 36. 00 37. 00 38. 00 Other Program Costs 0 0 37. 00 39. 00	21.00	Other	0	0			21. 00
23. 00		OTHER HOSPICE SERVICE COSTS					
24. 00 Sedatives / Hypnotics 0 0 24. 00 25. 00 Other - Specify 0 0 0 25. 00 26. 00 Durable Medical Equipment/Oxygen 0 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 0 31. 00 32. 00 Radiation Therapy 0 0 32. 00 33. 00 Other 0 0 33. 00 34. 00 Other 0 0 33. 00 34. 00 Other 0 0 35. 00 35. 00 Bereavement Program Costs 0 0 36. 00 37. 00 Fundraising 0 0 37. 00 38. 00 Other Program Costs 0 0 38. 00 39. 00	22.00	Drugs, Biological and Infusion Therapy	0	0			22. 00
25. 00 Other - Specify 0 0 0 0 25. 00 26. 00 27. 00 26. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00	Anal gesi cs	0	0			23. 00
26. 00 Durable Medical Equipment/Oxygen 0 0 27. 00 Patient Transportation 0 0 28. 00 Imaging Services 0 0 29. 00 Labs and Diagnostics 0 0 30. 00 Medical Supplies 0 0 31. 00 Outpatient Services (including E/R Dept.) 0 0 32. 00 Radiation Therapy 0 0 33. 00 Chemotherapy 0 0 34. 00 Other 0 0 HOSPICE NONREIMBURSABLE SERVICE 35. 00 Bereavement Program Costs 0 0 37. 00 Fundraising 0 0 38. 00 Other Program Costs 0 0 37. 00 Total Costs 0 0 38. 00 Other Program Costs 0 0 39. 00 Cost to be Allocated (per Wkst. K-4, Part I) 308,466 39.00	24.00	Sedatives / Hypnotics	0	0			24. 00
27. 00 Pati ent 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 0 31. 00 32. 00 Radiation Therapy 0 0 32. 00 33. 00 Chemotherapy 0 0 33. 00 34. 00 Other 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 8ereavement Program Costs 0 0 35. 00 35. 00 Vol unteer Program Costs 0 0 36. 00 37. 00 Fundraising 0 0 37. 00 38. 00 Other Program Costs 0 0 38. 00 39. 00 Cost to be Allocated (per Wkst. K-4, Part I) 308, 466 39. 00	25.00	Other - Specify	0	0			25. 00
28. 00	26.00	Durable Medical Equipment/Oxygen	0	0			26. 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 0 31. 00 32. 00 Radiation Therapy 0 0 32. 00 33. 00 Chemotherapy 0 0 33. 00 34. 00 Other 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 8 0 0 35. 00 36. 00 Vol unteer Program Costs 0 0 36. 00 37. 00 Fundraising 0 0 0 37. 00 38. 00 Other Program Costs 0 0 0 38. 00 39. 00 39. 00 Cost to be Allocated (per Wkst. K-4, Part I) 308, 466 39. 00 39. 00	27.00	Pati ent Transportation	0	0			27. 00
30.00 Medical Supplies 0 0 0 33.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 33.00 Other 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28.00	I maging Services	0	0			28. 00
31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 0 0 0	29.00	Labs and Diagnostics	0	0			29. 00
31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 0 0 0	30.00	Medi cal Supplies	o	0			30.00
33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00	Outpatient Services (including E/R Dept.)	O	0			31. 00
33.00 Chemotherapy 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32.00	Radi ati on Therapy	o	0			32. 00
HOSPICE NONREIMBURSABLE SERVICE	33.00		0	0			33. 00
35.00 Bereavement Program Costs 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 308,466	34.00	1	o	0			34.00
36.00 Volunteer Program Costs 0 0 0 37.00 37.00 Fundraising 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00 Cost to be Allocated (per Wkst. K-4, Part I) 308,466 36.00 39.00		HOSPICE NONREIMBURSABLE SERVICE					
37.00 Fundraising 0 0 37.00 38.00 Other Program Costs 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 308,466 39.00	35.00	Bereavement Program Costs	0	0			35. 00
38.00 Other Program Costs 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 308,466 39.00	36.00	Volunteer Program Costs	o	0			36.00
39.00 Cost to be Allocated (per Wkst. K-4, Part I) 308,466 39.00	37.00	Fundrai si ng	o	0			37. 00
	38. 00	Other Program Costs	o	0			38. 00
40.00 Unit Cost Multiplier 2.817942 40.00	39. 00	Cost to be Allocated (per Wkst. K-4, Part I)		308, 466			39. 00
	40.00	Unit Cost Multiplier		2. 817942			40.00

Health Financial Systems JASPER ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

						12/21/2015 2:	09 pm_
					Hospi ce I		
	·		CAPI TAL				
			RELATED COSTS				
	Cost Center Description	Hospi ce Tri al	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		Bal ance (1)	FLXT	BENEFITS		& GENERAL	
				DEPARTMENT			
		0	1.00	4. 00	4A	5. 00	
1.00	Administrative and General		4, 715	31, 011	35, 726	6, 679	1. 00
2.00	Inpatient - General Care	0	0	C	0	0	2.00
3.00	Inpatient - Respite Care	0	0	C	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	C	0	0	4. 00
5.00	Nursing Care	149, 366	0	l	149, 366	27, 925	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0	0	6. 00
7.00	Physical Therapy	0	0	l	0	0	7. 00
8.00	Occupational Therapy	0	0	d	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	d	0	0	9. 00
10.00	Medical Social Services	250, 934	0	d	250, 934	46, 915	
11. 00	Spiritual Counseling	0	0	d	0	0	11.00
12. 00	Di etary Counsel i ng	0	0	d	0	0	12.00
13. 00	Counseling - Other	0	0	Ĭ	0	Ö	13. 00
14. 00	Home Health Aide and Homemaker	17, 631	0	Ĭ	17, 631	3, 296	
15. 00	HH Aide & Homemaker - Cont. Home Care	1,700	0	7	0	0,2,0	15. 00
16. 00	Other		0		0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0	Ö	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	Ì	0	Ö	21.00
22. 00	Patient Transportation	0	0	Ì	0	0	22. 00
23. 00	Imaging Services					Ö	23. 00
24. 00	Labs and Diagnostics	0				Ö	24. 00
25. 00	Medical Supplies	0				ĺ	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0				o o	26. 00
27. 00	Radi ati on Therapy			7	0	0	27. 00
28. 00	Chemotherapy			7	0	0	28.00
29. 00	Other			7	0	0	29.00
30.00	Bereavement Program Costs				0		30.00
31. 00	Volunteer Program Costs					0	31.00
32.00	Fundrai si ng					0	32.00
33. 00	Other Program Costs					0	33.00
34. 00	Total (sum of lines 1 thru 33) (2)	417, 931	4, 715	31, 011	453, 657	84, 815	
35.00		417, 931	4, /15	31,011	0. 000000		35.00
35.00	Unit Cost Multiplier (see instructions)	I	I		0.000000	l	J 35. UU

Health Financial Systems JASPER ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS 151324 | Peri od: From 01/01/2014 | Part I | Worksheet K-5 | Part I | Date/Ti me Prepared: 12/21/2015 2: 09 pm Provider CCN: 151324 Hospi ce CCN:

						12/21/2013 2.	U 7 PIII
					Hospi ce I		
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7.00	8.00	9. 00	10.00	11. 00	
1.00	Administrative and General	3, 602	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	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	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	Di etary 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	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	I maging 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)	3, 602	0	0	0	0	34.00
35. 00	Unit Cost Multiplier (see instructions)		l				35. 00

PITAL In Lieu of Form CMS-2552-10

Provider CCN: 151324 | Period: From 01/01/2014 | Part I

Hospice CCN: 151519 | To 12/31/2014 | Date/Time Prepared: 12/21/2015 2:09 pm Health Financial Systems JASPER ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

							12/21/2015 2:	09 pm
					Hos	pice I		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MI	EDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &		RE(CORDS &		
			SUPPLY			I BRARY		
		13. 00	14.00	15. 00	•	16. 00	17. 00	
1.00	Administrative and General	0	0		0	C	0	1. 00
2.00	Inpatient - General Care	0	0		0	C	0	2. 00
3.00	Inpatient - Respite Care	0	0		0	C	0	3. 00
4.00	Physi ci an Servi ces	0	0		0	C	0	4. 00
5.00	Nursing Care	0	0		0	C	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0	C	0	6. 00
7.00	Physi cal Therapy	0	0		0	C	0	7. 00
8.00	Occupational Therapy	0	0		0	C	0	8. 00
9.00	Speech/ Language Pathology	0	0		0	C	0	9. 00
10.00	Medical Social Services	0	0		0	C	0	10. 00
11. 00	Spiritual Counseling	0	0		0	C	0	11. 00
12.00	Di etary Counsel i ng	0	0		0	C	0	12. 00
13.00	Counseling - Other	0	0		0	C	0	13. 00
14.00	Home Health Aide and Homemaker	0	0		0	C	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	C	0	15. 00
16.00	Other	0	0		0	C	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0	C	0	17. 00
18.00	Anal gesi cs	0	0		0	C	0	18. 00
19. 00	Sedatives / Hypnotics	0	0		0	C	0	19. 00
20.00	Other - Specify	0	0		0	C	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0		0	C	0	21. 00
22. 00	Pati ent Transportation	0	0		0	C	0	22. 00
23. 00	I maging Services	0	0		0	C	0	
24.00	Labs and Diagnostics	0	0		0	C	0	24. 00
25. 00	Medical Supplies	0	0		0	C	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0		0	C	0	26. 00
27. 00	Radi ati on Therapy	0	0		0	C	0	27. 00
28. 00	Chemotherapy	0	0		0	C	0	28. 00
29.00	Other	0	0		0	C	0	29. 00
30.00	Bereavement Program Costs	0	0		0	C	0	30. 00
31.00	Volunteer Program Costs	0	0		0	C	0	31.00
32.00	Fundrai si ng	0	0		0	C	0	32. 00
33.00	Other Program Costs	0	0		0	C	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	0		0	C	0	0 00
35. 00	Unit Cost Multiplier (see instructions)							35. 00

PITAL In Lieu of Form CMS-2552-10

Provider CCN: 151324 | Period: From 01/01/2014 | Part I

Hospice CCN: 151519 | To 12/31/2014 | Date/Time Prepared: 12/21/2015 2:09 pm Health Financial Systems JASPER ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

						12/21/2015 2:	09 pm
					Hospi ce I		
Cost Center Description		Subtotal	Intern &	Subtotal	Allocated	Total Hospice	
	·	(col s. 4A-23)	Residents Cost	(cols. 24 ±	Hospi ce A&G	Costs (cols.	
			& Post	25)	(See Part II)	26 ± 27)	
			Stepdown				
			Adjustments				
		24.00	25.00	26. 00	27. 00	28. 00	
1.00	Administrative and General	46, 007					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	177, 291	0	177, 291	16, 443	193, 734	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	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	297, 849	0	297, 849	27, 623	325, 472	10.00
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	13.00
14.00	Home Health Aide and Homemaker	20, 927	0	20, 927	1, 941	22, 868	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	I maging 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	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	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)	542, 074	0	542, 074		542, 074	34.00
35.00	Unit Cost Multiplier (see instructions)				0. 092744		35. 00

STATISTICAL BASIS

						12/21/2015 2:0	09 pm_
					Hospi ce I		
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	OPERATION OF	
		FLXT	BENEFITS		& GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
			SALARI ES)				
		1.00	4.00	5A	5. 00	7. 00	
1.00	Administrative and General	249	128, 606	C	35, 726	249	1. 00
2.00	Inpatient - General Care	0	0) c	0	0	2. 00
3.00	Inpatient - Respite Care	0	0) c	0	0	3. 00
4.00	Physi ci an Servi ces	o	0	ol c	0	0	4. 00
5.00	Nursing Care	o	O	l c	149, 366	0	5. 00
6.00	Nursing Care-Continuous Home Care	o	O	ol c	0	0	6. 00
7.00	Physical Therapy	o	0		0	0	7. 00
8.00	Occupational Therapy	o	0		0	0	8. 00
9.00	Speech/ Language Pathology	o	0		0	0	9. 00
10.00	Medical Social Services	l ol	0		250, 934	0	10.00
11. 00	Spiritual Counseling	l ol	0		0	o	11. 00
12. 00	Di etary Counseling	l ol	0		0	o	12.00
13. 00	Counseling - Other	l ol	0		0	o	13.00
14. 00	Home Health Aide and Homemaker	l ol	0		17, 631	o	14.00
15. 00	HH Aide & Homemaker - Cont. Home Care	l ol	0		0	o	15. 00
16, 00	Other	l ol	0		0	o	16, 00
17. 00	Drugs, Biological and Infusion Therapy	l ol	0	d	0	0	17. 00
18. 00	Anal gesi cs	l ol	0		0	0	18. 00
19. 00	Sedatives / Hypnotics	l ol	0		0	o	19. 00
20. 00	Other - Specify	l ol	0		0	o	20. 00
21. 00	Durable Medical Equipment/Oxygen	l ol	0		0	o	21. 00
22. 00	Patient Transportation	l ol	0		0	o	22. 00
23. 00	I maging Services	l ol	0		0	o	23. 00
24. 00	Labs and Diagnostics	l ol	0		0	o	24. 00
25. 00	Medical Supplies	l ol	0		0	o	25. 00
26. 00	Outpatient Services (including E/R Dept.)	l ol	0		0	o	26. 00
27. 00	Radiation Therapy	0	0		0	0	27. 00
28. 00	Chemotherapy	l ol	0	,	0	0	28. 00
29. 00	Other	l ol	0	,	0	0	29. 00
30. 00	Bereavement Program Costs	أم	0		0	Ö	30.00
31. 00	Volunteer Program Costs		n		ol ol	0	31.00
32. 00	Fundrai si ng		Ö	l č	n n	o o	32.00
33. 00	Other Program Costs		Ö	l č	n n	o o	33.00
34. 00	Total (sum of lines 1 thru 33) (2)	249	128, 606]	453, 657	249	34.00
35. 00	Total cost to be allocated	4, 715	31, 011		84, 815		35. 00
	4						
	Unit Cost Multiplier (see instructions)	18. 935743	0. 241132		0. 186958		

STATISTICAL BASIS

						12/21/2015 2:	09 pm
					Hospi ce I		
	Cost Center Description	LAUNDRY & LINEN SERVICE (DOLLAR VALUE)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	CAFETERI A (MAN HOURS)	NURSI NG ADMI NI STRATI ON (MAN	
						HOURS)	
	1	8. 00	9. 00	10.00	11. 00	13. 00	
1. 00	Administrative and General	0	0	1	-	0	1. 00
2.00	Inpatient - General Care	0	0	1	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	1	0	0	3. 00
4.00	Physi ci an Servi ces	0	0		0	0	4. 00
5.00	Nursing Care	0	0		0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0	0	6. 00
7.00	Physi cal Therapy	0	0		0	0	7. 00
8.00	Occupational Therapy	0	0		0	0	8. 00
9.00	Speech/ Language Pathology	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	Di etary Counsel i ng	0	0)	0	0	12. 00
13.00	Counseling - Other	0	0	1	0	0 0	13.00
14.00	Home Health Aide and Homemaker	0	0	1	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	o o	19. 00
20.00	Other - Specify	0	0)	0	o o	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0)	0	ol o	21. 00
22.00	Patient Transportation	0	0	1	0	ol o	22. 00
23.00	I maging Services	0	0	1	0	ol o	23. 00
24.00	Labs and Diagnostics	0	0	1	0	ol o	24. 00
25. 00	Medical Supplies	0	0)	0	ol o	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0)	0	ol o	26. 00
27. 00	Radi ati on Therapy	0	0)	0	ol o	27. 00
28. 00	Chemotherapy	0	0	,	0	ol o	28. 00
29. 00	Other	0	0	,	0	ol o	29. 00
30. 00	Bereavement Program Costs	0	0	,	0	ol o	30.00
31. 00	Volunteer Program Costs	0	0	,	0	ol o	31. 00
32. 00	Fundrai si ng	0	0	,	0	ol o	32. 00
33. 00	Other Program Costs	0	1 0	,	o	ol o	33.00
34. 00	Total (sum of lines 1 thru 33) (2)	0	l		O	ol o	34. 00
35. 00	Total cost to be allocated	0	ا	,	O	o o	35. 00
	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0.0000	0. 00000		

			nospi ce c	JON. 131317	10 12/31/2014	12/21/2015 2: 09 pm
					Hospi ce I	
	Cost Center Description	CENTRAL SERVICES &	PHARMACY (100%	MEDI CAL RECORDS &	SOCI AL SERVI CE	
		SUPPLY	ALLOCATION)	LIBRARY	(TIME	
		(100%		(TIME	SPENT)	
		ALLOCATION) 14.00	15. 00	SPENT) 16.00	17. 00	
1. 00	Administrative and General	14.00	15.00		0 0	1.00
2. 00	Inpatient - General Care		0			2.00
3.00	Inpatient - Respite Care		0			3.00
4. 00	Physi ci an Servi ces		0			4. 00
5. 00	Nursing Care		0			5. 00
6. 00	Nursing Care-Continuous Home Care		0			6. 00
7. 00	Physical Therapy		0		0	7. 00
8.00	Occupational Therapy		0		0	8. 00
9. 00	Speech/ Language Pathology	o	0	,	0	9.00
10. 00	Medical Social Services	o	0)	o o	10.00
11. 00	Spiritual Counseling	O	0)	o o	11. 00
12.00	Di etary Counseling	o	0)	0 0	12. 00
13.00	Counseling - Other	o	0)	0 0	13. 00
14.00	Home Health Aide and Homemaker	o	0)	0 0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	o	0	1	o o	15. 00
16. 00	Other	o	0)	0 0	16. 00
17.00	Drugs, Biological and Infusion Therapy	o	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
	Durable Medical Equipment/Oxygen	0	0	1	0 0	21. 00
22. 00	Patient Transportation	0	0)	0	22. 00
23. 00	I maging Services	0	0		0	23. 00
24. 00	Labs and Diagnostics	0	0		0	24. 00
	Medical Supplies	0	0		0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0		0 0	26. 00
27. 00	Radi ati on Therapy	0	0	1	0 0	27. 00
28. 00	Chemotherapy	0	0	1	0	28. 00
29. 00	Other	0	0	1	0	29. 00
30.00	Bereavement Program Costs	0	0	1	0	30.00
31.00	Volunteer Program Costs	0	0		0	31.00
32. 00	Fundrai si ng	0	0		0	32.00
33.00	Other Program Costs		0			33. 00 34. 00
34. 00 35. 00	Total (sum of lines 1 thru 33) (2) Total cost to be allocated		0			34.00
	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0. 00000	0. 000000	36.00
30.00	Join Coost Multiplier (See Histractions)	0. 000000	0. 000000	J 0.00000	0. 000000	36.00

Heal th	Financial Systems	JASPER COUNTY HO	SPI TAL		In Lie	eu of Form CMS-:				
COMPU	TATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 151324	Peri od:	Worksheet K-5				
				20N 1F1F10	From 01/01/2014	Part III				
			Hospi ce	CCN: 151519	To 12/31/2014	Date/Time Pre 12/21/2015 2:				
					Hospi ce I	12/21/2013 2.	оэ рш			
	Cost Center Description	Wks:	t. C. Part	Cost to Char	ge Total Hospice	Hospi ce Shared				
	, and the second		col . 11	Ratio	Charges	Ancillary				
			line		(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	1. 00			
1. 01	KV HEALTH PT		66. 01	•		0	1. 01			
2.00	OCCUPATI ONAL THERAPY		67. 00			0	2. 00			
2.01	KV HEALTH OT		67. 01	•		0	2. 01			
3.00	SPEECH PATHOLOGY		68. 00	•		0				
3. 01	KV HEALTH ST		68. 01	•		0	3. 01			
4.00	DRUGS CHARGED TO PATIENTS		73. 00		15 0	0	4. 00			
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00	•			5. 00			
6.00	LABORATORY		60.00	•		0				
6. 01	BLOOD LABORATORY		60. 01			0	6. 01			
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71. 00	•		0				
8.00	FAMILY PRACTICE		93.00	0.0000	00	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)			1		0	11. 00			

Health Financial Systems	JASPER COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF HOSPICE PER DIEM COST	Provi der CCN: 151324	Period: Worksheet K-6 From 01/01/2014
	Hospi ce CCN: 151519	To 12/31/2014 Date/Time Prepared: 12/21/2015 2:09 pm

				Hospi ce I		
		Title XVIII	Title XIX	Other	Total	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total cost (see instructions)				542, 074	1. 00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				5, 313	2.00
3.00	Average cost per diem (line 1 divided by line 2)				102. 03	3.00
4.00	Upduplicated Medicare Days (Worksheet S-9, column 1, line	4, 233				4.00
	5)					
5.00	Aggregate Medicare cost (line 3 time line 4)	431, 893				5. 00
6.00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line		48			6. 00
	5)					
7.00	Aggregate Medicaid cost (line 3 time line 60)		4, 897			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)			1, 032		12.00
13.00	Aggregate cost for other days (line 3 times line 12)			105, 295		13.00

	Financial Systems IS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDER	JASPER COUNT RALLY QUALIFIED		CCN: 151324	Peri od:	u of Form CMS-2 Worksheet M-1	
EALTH	CENTER COSTS		Component	CCN: 153990	From 01/01/2014 To 12/31/2014	Date/Time Pre 12/21/2015 2:	
					Rural Health Clinic (RHC) I	Cost	
		Compensation	Other Costs		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	1.00	2.00	0.00	1. 00	0.00	
. 00	Physi ci an	0	0		0 0	0	1.0
. 00	Physician Assistant	o	0		0 0	0	2.0
. 00	Nurse Practitioner	97, 941	0	97, 9	41 0	97, 941	3.0
. 00	Visiting Nurse	o	0		0 0	0	4.0
. 00	Other Nurse	37, 099	0	37, 0	99 0	37, 099	5.0
. 00	Clinical Psychologist	0	0		0 0	0	6. 0
. 00	Clinical Social Worker	0	0		0 0	0	7.0
. 00	Laboratory Techni ci an	0	0		0 0	0	
. 00	Other Facility Health Care Staff Costs	0	0		0 0	0	1
0. 00	Subtotal (sum of lines 1 through 9)	135, 040	0	135, 0		135, 040	
1. 00	Physician Services Under Agreement	0	28, 339	28, 3		28, 339	
2. 00	Physician Supervision Under Agreement	0	0		0 0	0	12.
3. 00	Other Costs Under Agreement	0	0		0 0	0	
4. 00	Subtotal (sum of lines 11 through 13)	0	28, 339	28, 3		28, 339	1
5. 00	Medical Supplies	0	25, 058	25, 0		25, 058	1
6. 00	Transportation (Health Care Staff)	0	0		0	0	
7.00	Depreciation-Medical Equipment	0	0		0	0	1
8. 00 9. 00	Professional Liability Insurance Other Health Care Costs	U O	0		0	0	
9. 00 D. 00	Allowable GME Costs	O O	0		0 0	0	1
1. 00	Subtotal (sum of lines 15 through 20)	0	25, 058	25, 0	-	25, 058	
2. 00	Total Cost of Health Care Services (sum of	135, 040	53, 397	188, 4		188, 437	
2.00	lines 10, 14, and 21)	133, 040	33, 377	100, 4.	57	100, 437	22.
	COSTS OTHER THAN RHC/FQHC SERVICS						
3. 00	Pharmacy	0	0		0 0	0	23.
4. 00	Dental	o	0		0 0	0	24.
5. 00	Optometry	o	0		0 0	0	25.
6. 00	All other nonreimbursable costs	o	0		0 0	0	26.
7. 00	Nonallowable GME costs	0	0		0 0	0	27.
8. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.
	through 27)						
	FACILITY OVERHEAD	_1	_		al -	_	
9. 00	Facility Costs	0	0	0. 5	0 0	0	
0.00	Administrative Costs	52, 083	44, 896	96, 9		96, 979	1
1. 00	Total Facility Overhead (sum of lines 29 and	52, 083	44, 896	96, 9	79 0	96, 979	31.
2 00	30)	107 100	00 202	20E 4-	16 0	20E 414	22
2. 00	Total facility costs (sum of lines 22, 28 and 31)	187, 123	98, 293	285, 4°	10 0	285, 416	32.

Health Financial Systems	JASPER COUNTY HOS	SPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RURAL I	HEALTH CLINIC/FEDERALLY QUALIFIED	Provider CCN: 151324	Peri od: From 01/01/2014	Worksheet M-1
HEALTH CENTER COSTS		Component CCN: 153990	To 12/31/2014	
			Rural Health	Cost

				Rural Health	Cost
		Adiustmonts	Net Expenses	Clinic (RHC) I	
		Adjustments	for Allocation		
			(col. 5 + col.		
			6)		
		6. 00	7.00	-	
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00		
1.00	Physi ci an	0			1.00
2.00	Physician Assistant	0		-1	2.00
3.00	Nurse Practitioner	0	97, 94		3. 00
4. 00	Vi si ti ng Nurse	0	//, /-	<u>'</u>	4. 00
5.00	Other Nurse	0	37, 099		5.00
6. 00	Clinical Psychologist	0	37,09	7	6.00
7. 00	Clinical Social Worker	0))	7.00
8.00	II .	0	1		8. 00
	Laboratory Technician	0	(
9.00	Other Facility Health Care Staff Costs	0	105.04	-1	9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	135, 040		10.00
11.00	Physician Services Under Agreement	0	28, 339	1	11.00
12.00	Physician Supervision Under Agreement	0	(1	12. 00
13.00	Other Costs Under Agreement	0	(•	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	28, 339		14. 00
15. 00	Medical Supplies	0	25, 058	1	15. 00
16. 00	Transportation (Health Care Staff)	0	(1	16. 00
17. 00	Depreciation-Medical Equipment	0	(1	17. 00
18. 00	Professional Liability Insurance	0	(1	18. 00
	Other Health Care Costs	0	(1	19. 00
20. 00	Allowable GME Costs	0	(1	20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	25, 058		21. 00
22. 00	Total Cost of Health Care Services (sum of	0	188, 437	7	22. 00
	lines 10, 14, and 21)				
	COSTS OTHER THAN RHC/FQHC SERVICS				
23. 00	Pharmacy	0			23. 00
24. 00	Dental	0	(24. 00
25. 00	Optometry	0	(0	25. 00
26. 00	All other nonreimbursable costs	0	,		26. 00
27. 00	Nonallowable GME costs	0			27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	(28. 00
	through 27)				
	FACILITY OVERHEAD				
29. 00	Facility Costs	0		-	29. 00
30. 00	Administrative Costs	-6, 420		·	30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-6, 420	90, 559	9	31. 00
	30)				
32. 00	Total facility costs (sum of lines 22, 28	-6, 420	278, 996	b	32. 00
	and 31)		l		

Heal th	Financial Systems	JASPER COUNT	Y HOSPITAL		In Lie	u of Form CMS-:	2552-10
	SIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDE			CCN: 151324	Peri od:	Worksheet M-1	
HEALTH	I CENTER COSTS		Component	CCN: 158502	From 01/01/2014 To 12/31/2014	Date/Time Pre 12/21/2015 2:	
					Rural Health Clinic (RHC) IV	Cost	
		Compensation	Other Costs	Total (col. + col. 2)	1 Reclassifications	Reclassified Trial Balance (col. 3 + col.	
		1.00	2. 00	3.00	4. 00	4) 5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	3.00	
1. 00	Physi ci an	0	0		0 0	0	1.00
2. 00	Physician Assistant	o	Ö		0 0	ő	1
3. 00	Nurse Practitioner	103, 262	Ö	103, 20	52 0	103, 262	
4.00	Visiting Nurse	0	0		0 0	0	
5.00	Other Nurse	67, 731	0	67, 73	31 0	67, 731	5. 00
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	9. 00
10.00	Subtotal (sum of lines 1 through 9)	170, 993	0	170, 99	93 0	170, 993	10.00
11. 00	Physician Services Under Agreement	0	50, 346	50, 34	16 0	50, 346	11. 00
12.00	Physician Supervision Under Agreement	0	0		0	0	12. 00
13.00	Other Costs Under Agreement	0	0		0	0	
14. 00	Subtotal (sum of lines 11 through 13)	0	50, 346			50, 346	1
15. 00	Medical Supplies	0	25, 284	25, 28	34 0	25, 284	1
16. 00	Transportation (Health Care Staff)	0	0		0	0	
17. 00	Depreciation-Medical Equipment	0	0		0	0	
18.00	Professional Liability Insurance	0	0		0	0	
19.00	Other Health Care Costs	0	0		0	0	
20.00	Allowable GME Costs	0	0	25 26	0	0	
21. 00	Subtotal (sum of lines 15 through 20)	170 003	25, 284			25, 284	1
22. 00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	170, 993	75, 630	246, 62	23 0	246, 623	22. 00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23. 00	Pharmacy	O	0		0 0	0	23. 00
24. 00	Dental	0	0			0	
25. 00	Optometry	0	0			0	25. 00
26. 00	All other nonreimbursable costs	0	0			0	
27. 00	Nonallowable GME costs	0	0		0 0	Ö	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	o o	
	through 27)						
	FACILITY OVERHEAD				•		1
29. 00	Facility Costs	0	0		0 0	0	29. 00
30.00	Administrative Costs	18, 244	31, 834	50, 0	78 0	50, 078	30.00
31.00	Total Facility Overhead (sum of lines 29 and	18. 244	31, 834	50.0	78 0	50, 078	31.00

18, 244

189, 237

31, 834

107, 464

50, 078

296, 701

0

50, 078

296, 701

31.00

32.00

31.00 Total Facility Overhead (sum of lines 29 and 30)
32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	JASPER COUNTY HOS	SPI TAL	In Lieu	u of Form CMS-2552-10
	HEALTH CLINIC/FEDERALLY QUALIFIED	Provider CCN: 151324	Peri od: From 01/01/2014	Worksheet M-1
HEALTH CENTER COSTS		Component CCN: 158502	To 12/31/2014	
			Rural Health	Cost

					Rural Health	Cost	
		Λ -l: + · · - · - + -	Nat Francis		Clinic (RHC) IV		
		Adjustments	Net Expens				
			(col. 5 + c				
			6)	.01 .			
		6. 00	7.00				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
1.00	Physi ci an	0)	0			1. 00
2.00	Physi ci an Assi stant	0)	o			2. 00
3.00	Nurse Practitioner	0	103,	262			3. 00
4.00	Visiting Nurse	0		О			4. 00
5.00	Other Nurse	0	67,	731			5. 00
6.00	Clinical Psychologist	0		О			6. 00
7.00	Clinical Social Worker	0)	О			7. 00
8.00	Laboratory Techni ci an	0)	О			8. 00
9.00	Other Facility Health Care Staff Costs	0	o l	О			9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	170,	993			10.00
11.00	Physician Services Under Agreement	0	50,	346			11. 00
12.00	Physician Supervision Under Agreement	0)	О			12.00
13.00	Other Costs Under Agreement	0		О			13.00
14.00	Subtotal (sum of lines 11 through 13)	0	50,	346			14.00
15.00	Medical Supplies	0	25,	284			15.00
16.00	Transportation (Health Care Staff)	0)	0			16.00
17.00	Depreciation-Medical Equipment	0)	0			17.00
18.00	Professional Liability Insurance	0)	0			18.00
19.00	Other Health Care Costs	0)	0			19.00
20.00	Allowable GME Costs	0)	0			20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	25,	284			21. 00
22. 00	Total Cost of Health Care Services (sum of	0	246,	623			22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICS						
23. 00	Pharmacy	0)	0			23. 00
24. 00	Dental	0)	0			24. 00
25. 00	Optometry	0)	0			25. 00
26.00	All other nonreimbursable costs	0)	0			26. 00
27. 00	Nonallowable GME costs	0)	0			27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	Ü)	0			28. 00
	through 27) FACILITY OVERHEAD						
29. 00	Facility Costs	0	1	0			29. 00
30.00	Administrative Costs	0	1	078			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0		078			31. 00
31.00	30)	U	, 50,	0,0			31.00
32. 00	Total facility costs (sum of lines 22, 28	0	296,	701			32. 00
02.00	and 31)	Ö]				52.00
	1		1	1		'	1

	Financial Systems TION OF OVERHEAD TO RHC/FQHC SERVICES	JASPER COUNT			CCN: 151324	Peri od:	u of Form CMS-2 Worksheet M-2	
ALLOGA	THON OF OVERHEAD TO KNOT GIO SERVI GES		1100	/ I del		From 01/01/2014	WOLKSHEET W. Z	
			Comp	onent	CCN: 153990	To 12/31/2014	Date/Time Prep 12/21/2015 2:0	
						Rural Health Clinic (RHC) I	Cost	
		Number of FTE	Total Vis	si ts	Producti vi tv	Minimum Visits	Greater of	
		Personnel			Standard (1)	(col. 1 x col.	col. 2 or col.	
						3)	4	
		1.00	2.00		3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY							
	Posi ti ons	1	Τ			_1		
1.00	Physi ci an	0. 00	•	0	4, 20			1.00
2.00	Physician Assistant	0.00		0	_,			2.00
3.00	Nurse Practitioner	1. 45		3, 270			0.070	3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 45		3, 270		3, 045	3, 270	
5.00	Visiting Nurse	0.00		0			0	5. 00
6.00	Clinical Psychologist	0.00	•	0			0	6.00
7.00	Clinical Social Worker Medical Nutrition Therapist (FQHC only)	0.00		0			0	7.00
7. 01 7. 02		0. 00 0. 00		0			0	7. 01 7. 02
7.02	Diabetes Self Management Training (FQHC only)	0.00		U			U	7.02
8. 00	Total FTEs and Visits (sum of lines 4	1. 45		3, 270			3, 270	8.00
0.00	through 7)	1. 43	,	3, 270			3, 270	0.00
9.00	Physician Services Under Agreements			134			134	9. 00
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	RHC/FQHC SERV	'I CES					
10.00	Total costs of health care services (from Wks	st. M-1, col. 7	, line 22	!)			188, 437	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)				0	11. 00
12.00	Cost of all services (excluding overhead) (se		and 11)				188, 437	
13.00	Ratio of RHC/FQHC services (line 10 divided						1. 000000	
14.00	Total facility overhead - (from Wkst. M-1, co						90, 559	
15. 00	Parent provider overhead allocated to facili	ty (see instruc	ctions)				105, 717	
16. 00	Total overhead (sum of lines 14 and 15)						196, 276	
17. 00	Allowable GME overhead (see instructions)						0	17. 00
	Subtotal (see instructions)						196, 276	
	Overhead applicable to RHC/FQHC services (li						196, 276	
20. 00	Total allowable cost of RHC/FQHC services (se	um of lines 10	and 19)				384, 713	20.00

Heal th	Financial Systems	JASPER COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES		Provi d	er CCN: 151324	Peri od:	Worksheet M-2	
			Compone	ent CCN: 158502	From 01/01/2014 To 12/31/2014		
					Rural Health Clinic (RHC) IV	Cost	
		Number of FTE	Total Visit	s Productivit	y Minimum Visits		
		Personnel	l lotal Visit) (col. 1 x col.		
				o tanaan a (3)	4	
		1. 00	2, 00	3.00	4. 00	5.00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						1
1.00	Physi ci an	0.00		0 4, 2	00)	1. 00
2.00	Physician Assistant	0.00		0 2, 1	00)	2. 00
3.00	Nurse Practitioner	1. 10	4, 6	01 2, 1	00 2, 310)	3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 10	4, 6	01	2, 310	4, 601	4. 00
5.00	Visiting Nurse	0.00		0		0	5. 00
6.00	Clinical Psychologist	0.00		0		0	6. 00
7.00	Clinical Social Worker	0.00		0		0	
7.01	Medical Nutrition Therapist (FQHC only)	0.00		0		0	
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	1. 10	4, 6	01		4, 601	8. 00
	through 7)		_				
9. 00	Physician Services Under Agreements] 3	94		394	9. 00
						1 00	
	DETERMINATION OF ALLOWARDS COOK ARRESTS TO					1.00	
40.00	DETERMINATION OF ALLOWABLE COST APPLICABLE TO					1 04/ /00	10.00
10.00	Total costs of health care services (from Wk					246, 623	1
11.00	Total nonreimbursable costs (from Wkst. M-1,					0	
12.00	Cost of all services (excluding overhead) (si		and II)			246, 623	
13.00	Ratio of RHC/FQHC services (line 10 divided					1.000000	1
14. 00 15. 00	Total facility overhead - (from Wkst. M-1, co					50, 078	1
16. 00	Parent provider overhead allocated to facili Total overhead (sum of lines 14 and 15)	ty (see instruc	LI UIIS)			207, 535 257, 613	
17. 00	Allowable GME overhead (see instructions)					257, 613	1
	Subtotal (see instructions)					257, 613	
	Overhead applicable to RHC/FQHC services (li	no 13 v lino 10	8)			257, 613	1
	Total allowable cost of RHC/FQHC services (si					504, 236	1
20.00	Tiotal allowable cost of Michiglic services (si	um of filles to	ana 17)			1 304, 230	1 20.00

Heal th	Financial Systems JASPER COUNTY HO	SPI TAI	Inlie	u of Form CMS-2	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provi der CCN: 151324	Peri od:	Worksheet M-3	1002 10
		Component CCN: 153990	From 01/01/2014 To 12/31/2014	Date/Time Pre	
		Title XVIII	Rural Health Clinic (RHC) I	Cost	
	I			1. 00	
1 00	DETERMINATION OF RATE FOR RHC/FOHC SERVICES	20)		204 712	1 00
1. 00 2. 00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, line Cost of vaccines and their administration (from Wkst. M-4, line			384, 713 2, 590	1. 00 2. 00
3.00	Total allowable cost excluding vaccine (line 1 minus line 2)	15)		382, 123	3. 00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			3, 270	4. 00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, li	ne 9)		134	5. 00
6.00	Total adjusted visits (line 4 plus line 5)	•		3, 404	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			112. 26	7. 00
			Cal cul ati on	of Limit (1)	
			Prior to	On on After	
			January 1	January 1	
			1. 00	2. 00	
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6	or your contractor)	79. 80	79. 80	8. 00
9. 00	Rate for Program covered visits (see instructions)		112. 26	112. 26	9. 00
10. 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from c	ontractor records)	O	216	10. 00
11. 00	Program cost excluding costs for mental health services (line 9		o	24, 248	11. 00
12. 00	Program covered visits for mental health services (from contrac	,	o	21, 210	12. 00
13. 00	Program covered cost from mental health services (line 9 x line	•	o	0	13. 00
14.00	Limit adjustment for mental health services (see instructions)	ŕ	o	0	14. 00
15. 00	Graduate Medical Education Pass Through Cost (see instructions)			0	15. 00
16.00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 a	,		24, 248	
16. 01	Total program charges (see instructions)(from contractor's reco			22, 435	16. 01
16. 02	Total program preventive charges (see instructions) (from provid			1, 510	
16. 03 16. 04	Total program preventive costs ((line 16.02/line 16.01) times I Total Program non-preventive costs ((line 16 minus lines 16.03			1, 632	16. 03 16. 04
10. 04	(Titles V and XIX see instructions.)	and 18) trilles .80)		14, 939	10. 04
16. 05	Total program cost (see instructions)			16, 571	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) (from contractor		3, 942	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor		3, 397	19. 00
	records)	, (110 00.111.4010.		·	
20.00	Net Medicare cost excluding vaccines (see instructions)	4 11 44		16, 571	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst. M	-4, line 16)		457	21. 00
22. 00 23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			17, 028 0	22. 00 23. 00
23. 00	Adjusted reimbursable bad debts (see instructions)			0	23. 00
24. 00	, , , , , , , , , , , , , , , , , , , ,	ctions)		0	24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	21.01.3)		0	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	25. 50
26.00	Net reimbursable amount (see instructions)			17, 028	26. 00
26. 01	Sequestration adjustment (see instructions)			341	26. 01
27. 00	Interim payments			16, 037	27. 00
28. 00	Tentative settlement (for contractor use only)			0	28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 27, a			650	29. 00
30. 00	Protested amounts (nonallowable cost report items) in accordance chapter I, §115.2	e with two Pub. 15-11,		0	30. 00
	Onapto: 1, 3110.2		ı	ļ	ı

CALCULA	TION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provi der CCN: 151324	Peri od:	Worksheet M-3	
		Component CCN: 158502	From 01/01/2014 To 12/31/2014	Date/Time Prep 12/21/2015 2:0	pared: 09 pm
		Title XVIII	Rural Health Clinic (RHC) IV	Cost	•
			CITITIC (KIIC) TV		
15				1. 00	
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, lin	20)		504, 236	1.00
	Cost of vaccines and their administration (from Wkst. M-4, lin			8, 038	2.00
	Total allowable cost excluding vaccine (line 1 minus line 2)	,		496, 198	3.00
	Total Visits (from Wkst. M-2, column 5, line 8)			4, 601	4.00
	Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		394	5. 00
	Total adjusted visits (line 4 plus line 5)			4, 995	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	99.34	7. 00
			Car car a troir		
			Prior to	On on After	
			January 1 1.00	January 1 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	79. 80	79. 80	8. 00
	Rate for Program covered visits (see instructions)	o o. you. cont. doto.	99. 34	99. 34	
(CALCULATION OF SETTLEMENT				
	Program covered visits excluding mental health services (from		0	737	10.00
	Program cost excluding costs for mental health services (line		0	73, 214	
	Program covered visits for mental health services (from contra Program covered cost from mental health services (line 9 x lin		0	0	12. 00 13. 00
	Limit adjustment for mental health services (see instructions)			0	14.00
	Graduate Medical Education Pass Through Cost (see instructions			Ö	15. 00
	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			73, 214	16.00
	Total program charges (see instructions)(from contractor's rec			52, 521	16. 01
	Total program preventive charges (see instructions)(from provi Total program preventive costs ((line 16.02/line 16.01) times			770 1, 073	
	Total Program non-preventive costs ((Time 16.02/Time 16.01) times Total Program non-preventive costs ((Line 16 minus Lines 16.03			47, 639	16. 03
	(Titles V and XIX see instructions.)	and roy trines . ooy		47,037	10.0-
16. 05	Total program cost (see instructions)			48, 712	16. 05
	Primary payer amounts			0	17. 00
	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		12, 592	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction records)	s) (from contractor		7, 832	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			48, 712	20.00
	.00 Program cost of vaccines and their administration (from Wkst. M-4, line 16)			6, 221	21.00
	Total reimbursable Program cost (line 20 plus line 21)			54, 933	
	Allowable bad debts (see instructions)			0	23. 00 23. 01
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eliqible beneficiaries (see instr	uctions)		0	24.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	4011 0113)		0	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	
	Net reimbursable amount (see instructions)			54, 933	
	Sequestration adjustment (see instructions)			1, 099	
	Interim payments			52, 843 0	27. 00 28. 00
	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 27,	and 28)		991	28. 00 29. 00
	parance due component/program (fine 26 minus fines 26.01, 27, Protested amounts (nonallowable cost report items) in accordan			991	30.00
	chapter I, §115.2			-	

Heal th	Financial Systems JASPER COUNTY HO	SPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provi der CCN: 151324	Peri od:	Worksheet M-4	
			From 01/01/2014		
		Component CCN: 153990	To 12/31/2014	Date/Time Pre	
		Title XVIII	Rural Health	12/21/2015 2: Cost	J9 pili
		II tie xviii	Clinic (RHC) I	COST	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		135, 040	135, 040	1. 00
	l	hoolth come staff tim		0. 002738	2. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total		0.000067		
3.00	Pneumococcal and influenza vaccine health care staff cost (line	•	9	370	3. 00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fro	,	/0	820	4. 00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus		79	1, 190	5. 00
6. 00	Total direct cost of the facility (from Wkst. M-1, col. 7, line	22)	188, 437	188, 437	6. 00
7.00	Total overhead (from Wkst. M-2, line 16)		196, 276	196, 276	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total	al direct cost (line 5	0. 000419	0.006315	8. 00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x li	ne 8)	82	1, 239	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their) a	administration (sum of	161	2, 429	10.00
	lines 5 and 9)	•		•	
11.00	Total number of pneumococcal and influenza vaccine injections (from your records)	1	41	11. 00
12. 00	Cost per pneumococcal and influenza vaccine injection (line 10/		161.00	59. 24	12. 00
	Number of pneumococcal and influenza vaccine injections adminis	•	1	5	13. 00
	honoficing ice	co. ca to ogram		O	

Program cost of pneumococcal and influenza vaccine and its (their) administration

administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,

15.00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)

16.00 Total Program cost of pneumococcal and influenza vaccine and its (their)

296

2, 590

457

161

14.00

15.00

16.00

14.00

benefi ci ari es

line 21)

(line 12 x line 13)

Health Financial Systems	JASPER COUNTY HO	SPI TAL				In Lie	u of Form CMS-2	2552-10
COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VAC	CINE COST	Provi der	CCN:	151324		d: 01/01/2014	Worksheet M-4	
		Component	CCN:	158502			Date/Time Pre 12/21/2015 2:	
		Title	e XVI	П	Rura	al Health	Cost	
					Clini	c (RHC) IV		

		I			
			Clinic (RHC) IV		
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00 Health care staff cost (from	Wkst. M-1, col. 7, line 10)		170, 993	170, 993	1.00
2.00 Ratio of pneumococcal and inf	Tuenza vaccine staff time to total	health care staff time	0. 000816	0. 003863	2.00
3.00 Pneumococcal and influenza va	ccine health care staff cost (line	1 x line 2)	140	661	3.00
4.00 Medical supplies cost - pneum	ococcal and influenza vaccine (from	m your records)	1, 330	1, 800	4.00
5.00 Direct cost of pneumococcal a	ind influenza vaccine (line 3 plus l	line 4)	1, 470	2, 461	5. 00
6.00 Total direct cost of the faci	lity (from Wkst. M-1, col. 7, line	22)	246, 623	246, 623	6. 00
7.00 Total overhead (from Wkst. M-	2, line 16)		257, 613	257, 613	7. 00
8.00 Ratio of pneumococcal and inf	Tuenza vaccine direct cost to total	I direct cost (line 5	0. 005961	0. 009979	8. 00
divided by line 6)					
9.00 Overhead cost - pneumococcal	and influenza vaccine (line 7 x line	ne 8)	1, 536	2, 571	9. 00
10.00 Total pneumococcal and influe	enza vaccine cost and its (their) a	dministration (sum of	3, 006	5, 032	10.00
lines 5 and 9)					
11.00 Total number of pneumococcal	and influenza vaccine injections (from your records)	19	90	11.00
12.00 Cost per pneumococcal and inf	Tuenza vaccine injection (line 10/1	line 11)	158. 21	55. 91	12.00
13.00 Number of pneumococcal and in	ifluenza vaccine injections adminis	tered to Program	16	66	13.00
benefi ci ari es					
14.00 Program cost of pneumococcal	and influenza vaccine and its (the	ir) administration	2, 531	3, 690	14.00
(line 12 x line 13)					
15.00 Total cost of pneumococcal an	d influenza vaccine and its (their)) administration (sum		8, 038	15. 00
of cols. 1 and 2, line 10) (t	ransfer this amount to Wkst. M-3,	line 2)			
16.00 Total Program cost of pneumoc	occal and influenza vaccine and its	s (their)		6, 221	16. 00
`	1 and 2, line 14) (transfer this ar	mount to Wkst. M-3,			
line 21)					

Health Financial Systems	JASPER COUNTY HOS ED RHC/FQHC PROVIDER FOR SERVICES	OSPI TAL	In Lieu of Form CMS-2552-10				
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RENDERED TO PROGRAM BENEFICIARIES	RHC/FQHC PROVI DER FOR SERVI CE	Provider CCN: 151324	Peri od: From 01/01/2014	Worksheet M-5			
REINDERED TO FROGRAM BENEFICIARIES		Component CCN: 153990					
			Rural Health	Cost			

				12/21/2013 2.0	0 / pi
			Rural Health	Cost	
			Clinic (RHC) I		
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
. 00	Total interim payments paid to provider		1.00	16, 037	1.
. 00	Interim payments payable on individual bills, either submitte	ad as to be submitted to		10,037	2.
. 00				U	2.
	the contractor for services rendered in the cost reporting pe	erioa. It none, write			
	"NONE" or enter a zero				
. 00	List separately each retroactive lump sum adjustment amount &				3.
	revision of the interim rate for the cost reporting period. A	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				ĺ
01				0	3.
. 02				ol	3.
03				l ől	3.
04					3.
05				0	3.
	Provi der to Program				
50				0	
51				0	3.
52				0	3.
53				ol	3.
54				ol	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98	8)		0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfe			16, 037	4.
00	27)	er to worksheet w 5, Title		10,037	٦.
	TO BE COMPLETED BY CONTRACTOR				
00			.		_ ا
00	List separately each tentative settlement payment after desk	review. Also show date of			5.
	each payment. If none, write "NONE" or enter a zero. (1)				ļ
	Program to Provider				
01				0	5.
02				0	5.
03				0	5.
	Provider to Program			,	İ
50				0	5.
51				0	5
52				l ől	5
99		9)			5
00	Determined net settlement amount (balance due) based on the d	cost report. (I)			6.
01	SETTLEMENT TO PROVI DER			650	6.
02	SETTLEMENT TO PROGRAM			0	6.
00	Total Medicare program liability (see instructions)			16, 687	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	

Health Financial Systems	JASPER COUNTY HOSPI BASED RHC/FQHC PROVI DER FOR SERVI CES P	ΓΥ HOSPI TAL	SPI TAL			In Lieu of Form CMS-2552				
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RENDERED TO PROGRAM BENEFICIARIES	RHC/FQHC PROVIDER FOR SERV	I CES Provi der	CCN: 151			1/01/2014	Worksheet M-5			
RENDERED TO PROGRAW BENEFIT CLARIES		Componen ⁻	t CCN: 15				Date/Time Prepared: 12/21/2015 2:09 pm			
						Health (RHC) IV	Cost			

			Rural Health	Cost	
			Clinic (RHC) IV		
				t B	
			mm/dd/yyyy	Amount	
I			1. 00	2. 00	
	I interim payments paid to provider			52, 843	
	rim payments payable on individual bills, either submitted contractor for services rendered in the cost reporting pe			0	2.
	E" or enter a zero	riod. II none, write			
	separately each retroactive lump sum adjustment amount by	asod on subsequent			3.
rovis	sion of the interim rate for the cost reporting period. A	Iso show date of each			ا ا
navme	ent. If none, write "NONE" or enter a zero. (1)	iso snow date of each			
	ram to Provider				l
01	diii to 11 ovi dei			0	3.
02				0	
03				Ö	
04				0	
05				0	
	der to Program			_	1
50				0	1 3
51				ol	3.
52				ol	3.
53				o	
54				o	3
99 Subto	otal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		o	3
	Linterim payments (sum of lines 1, 2, and 3.99) (transfe			52, 843	4.
27)				·	
TO BE	E COMPLETED BY CONTRACTOR				1
	separately each tentative settlement payment after desk	review. Also show date of	7		5.
	payment. If none, write "NONE" or enter a zero. (1)				
	ram to Provider				
01				0	~
02				0	
03				0	5
	der to Program				
50				0	_
51				0	-
52				0	_
	otal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5
	rmined net settlement amount (balance due) based on the co	ost report. (1)			6
	LEMENT TO PROVIDER			991	6
	LEMENT TO PROGRAM			0	"
00 Total	l Medicare program liability (see instructions)			53, 834	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
1		0	1. 00	2. 00	8.
00 Name	of Contractor		1		